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# THE TREATMENT OF DEPRESSIVE CONDITIONS WITH IMIPRAMINE (G 22355)*

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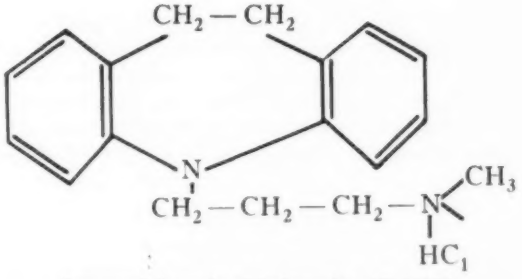
While the mechanism of action of phenothiazine and rauwolfia derivatives is not yet clearly established, most clinical workers agree that they are most effective in syndromes associated with euphoric, hostile and anxious affect. In depressive states, their therapeutic action has on the whole been rather disappointing. Phenothiazine derivatives seem at times to promote a shift from a manic to a depressive reaction in predisposed individuals, while reserpine not infrequently produces marked depressive symptoms if given over an extended period of time.

A variety of treatment methods has been tried in the management of psychiatric depressions. For many years oral administration of tincture opii was the treatment of choice.(1) The amphetamines enjoyed a short-lived popularity (2) and steroid hormones were recommended for the treatment of endogenous depression (3, 4, 5) particularly those of the involutional type. Hematoporphyrin (6, 7) and other photosensitizing agents have also been credited with therapeutic effects, as well as dinitrile succinate (8) and nicotinic acid (9, 10). Different physical procedures have been suggested, e.g. the artificial induction of anoxia (11) and even x-ray irradiation (12) while leucotomy has still a place as a last resort procedure. None of these treatments, however, has been as reliable and prompt in action as convulsive therapy.

Recently the pharmacological treatment of depressive conditions has again moved into the focus of psychiatric interest. Considerable chemotherapeutic success in the treatment of depressive states has been reported with the use of iproniazid (13, 14, 15) a drug with stimulant properties which become manifest within two to four weeks. Another drug, Imipramine (G 22355), has been




Structural formula of Imipramine (G 22355)

claimed by Kuhn in Switzerland (16) to have given excellent results with depressed patients. In the following we are reporting our experience with this substance.

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### Psychopharmacological Characteristics

Chemically, the drug is N-(3'dimethylamino-propyl)-iminodibenzyl hydrochloride. (16, 17) Its structural formula is reminiscent of the phenothiazine derivatives. The iminodibenzyl nucleus differs from the phenothiazine nucleus only in that the sulphur atom of the latter is replaced by a short two-carbon chain in the former.

The substance is a whitish-pink crystalline powder which is water-soluble and stable under normal conditions.

Its toxicity is lowest in small animals:

| | |
|---|---|
| $LD_{50}$ mg./kg. i.v. mouse: | 38 |
| rat: | 25 |
| rabbit: | 15 |

Its spasmolytic action on rabbit intestine is three times that of papaverine. It has pronounced anti-serotonin activity on the guinea pig ileum but is not a potent antagonist of adrenalin or nor-adrenalin. It produces distinct potentiation of barbiturate anesthesia in the mouse.

The iminodibenzyl derivatives were originally investigated by Kuhn for their hypnotic-sedative action, which is, however, not very pronounced.

In our own psychopharmacological laboratory we found that Imipramine (G 22355) depresses or inhibits most of the perceptual, psychomotor and cognitive functions tested by our methods (18), and, compared to neuroleptic drugs such as the phenothiazine derivatives or reserpine, Imipramine (G 22355) seems to exert more pronounced effects on the cerebral cortex.

One higher cerebral function, however, was significantly facilitated in normal volunteers following a single dose of the drug, namely, word fluency, as tested by the ability to name as many round objects as possible in a given time. The significance of this isolated increase in verbal facility remains obscure at this stage and may be related to dosage level.

The effects of the drug on the human EEG were inconclusive in our material.

### Procedure

*Selection*

Eighty-four patients (60 females and 24 males) were chosen on the basis of having a depressive syndrome as the principal, or at least as a prominent clinical feature.

Three-fifths of the total number fell into the broad group of 'endogenous depressions' (manic-depressive psychoses in the depressed phase, involutional melancholias). The remainder belonged to a variety of diagnostic categories (Table I).

TABLE I: DIAGNOSTIC GROUPS

| | |
|---|---|
| Manic-depressive | 39 |
| Involutional Melancholia | 12 |
| Schizophrenias and Schizo-affective disorders | 11 |
| Senile and Arteriosclerotic | 7 |
| Pathological Personalities (cyclothymic) | 6 |
| Neurotic Depressive Reactions | 5 |
| Mixed Psychoneuroses | 4 |
| TOTAL | 84 |

TABLE II: DEPRESSION RATING SCORE

| | 3 | 2 | 1 | 0 | Score |
|---|---|---|---|---|---|
| 1. Mood | Severely depressed | Moderately depressed | Mildly depressed | Not depressed | ..... |
| 2. Facies | Severely depressed | Moderately depressed | Mildly depressed | Not depressed | ..... |
| 3. Retardation | Intense | Moderate | Slight | None | ..... |
| 4. Agitation | Intense | Moderate | Slight | None | ..... |
| 5. Ideas of feelings of guilt, worthlessness, hopelessness, nihilistic delusions | Intense | Moderate | Mild | None | ..... |
| 6. Sleep (without drugs) | 0-3 hours | 3-5 hours | 5-7 hours | Over 7 hours | ..... |
| 7. Loss of weight (% of normal) | More than 25% | 10-25% | 5-10% | Less than 5% | ..... |
| | | | | Total | ..... |

An important factor in selection was the lack of observed benefit from other forms of therapy. On this basis, 41 patients who had become increasingly refractory to treatment over a number of years, and could therefore be classified as 'chronic', were nevertheless included in our sample and made up almost half of the total.

Average age was high (57 years), with a range from 20-88. One-quarter of the total were in the age group over 65 and three of these were over 80.

*Dosage and Methods of Administration*

Treatment was usually begun with a dosage schedule of 100 mgms. daily in four divided doses, administered by intramuscular injection. It was subsequently felt that there was little if any appreciable difference, either in efficacy or in speed of action, between the same oral and parenteral dose, and that the former could be routinely used.

Dosage was usually increased after a few days to 150 mgms daily and in a larger percentage to higher doses ranging from 200 to 600 mgms daily. The incidence of side effects increased rapidly when the daily dose exceeded 200 mgms and almost all patients were eventually kept at or below this dose.

In a small proportion of patients, it was found useful and practical to combine Imipramine (G 22355) therapy with other phrenotropic drugs such as hypnotics or neuroleptic agents, e.g. chlorpromazine.

**Methods of Assessment**

1. *Clinical Judgment and Rating Scale*

Recognizing the limitations of a double blind procedure, we decided to evaluate the drug first by relying on our clinical judgment. In order to reduce individual differences in assessment, a rating scale (Table II) was devised for the *ad hoc* purpose of evaluating the intensity of the depressive symptoms. Each patient was rated independently by two psychiatrists prior to the administration of the drug. It was soon established that the differences between the two raters were insignificant, hence this scale was used throughout the four months of this study. Patients were rated at intervals of two weeks for the first two months and monthly thereafter, also at other times if this was indicated.

Using this rating scale, we evaluated our results in terms of the percentage change in the individual patient's score. As base line we took the total score obtained before commencement of therapy. A 95-100 per cent reduction of the score was classified as 'Recovered', which meant that these patients had no residual evidence of depression, or practically none. A 50-95 per cent reduction of the score was classified as 'Much Improved', and these patients were generally considered to be well enough to leave the hospital. A 10-50 per cent reduction of the score was classified as 'Improved'; these patients' symptoms were reduced but not to the point where they could leave the hospital. The range of minus to plus 10 per cent change in the initial score was classified as 'Unimproved'; and an increase of the score of more than 10 per cent was classified as 'Worse'.

We found that the evaluation by means of the rating scale corresponded very closely to the usual clinical assessment by other methods, that is to say: interviews with patients, reports by nurses and other hospital personnel, reports from relatives and eventually trial discharge from the hospital.

Not all patients in the 'Recovered' and 'Much Improved' categories have actually left the hospital. Some will be leaving within the next month or so, some have other conditions necessitating further hospitalization (e.g. neurotic over-dependency, schizophrenia), and some are difficult to rehabilitate owing to lack of community resources.

It was of course realized that our rating scale could not be used to assess *all* the signs and symptoms of depression, but our intention was to evaluate quickly and efficiently the cardinal features.

2. *Double-Blind Experiment*

When the therapeutic trial was in full progress, we decided to make a partial check on our results, employing a double-blind procedure. At that time, 42 patients were receiving the drug. These patients were divided into two groups of 21 each, one for continuation of the drug, the other for placebo (same dose). We decided to administer the placebo tablets for two weeks, assuming that this was a sufficiently long period of time for differences betwen the drug and placebo group to become apparent. The hospital pharmacist was asked to choose at random the names of patients for either group, to label the bottles containing the tablets with the name of each patient, and to issue the 42 bottles to the ward nurses. He kept the code, which was broken after the two weeks. All the patients were rated according to the rating scale before the beginning of placebo study, and again before the code was broken.

**Results of Clinical Rating**

Table III shows the cumulative results obtained according to our rating scale.

Few patients recovered completely within two weeks of commencement of therapy, but about a quarter were much improved. Another quarter were unimproved or worse. Some of the latter developed complications, not necessarily serious ones, nevertheless it seemed wiser to discontinue treatment (see below).

After four weeks, the recovery rate had doubled; improvement was sustained and only two more patients had reacted unfavourably.

The greatest improvement in our sample occurred between the fourth and eighth week of therapy. By the end of the eighth week, nearly a quarter of all the patients had recovered, two-fifths were much improved, another quarter improved somewhat, and only 15 per cent showed no improvement; the latter figure includes those patients whose treatment had been discontinued early for various reasons.

TABLE III: RESULTS OF TREATMENT WITH IMIPRAMINE (G 22355)

| | After 2 weeks | After 4 weeks | After 8 weeks |
|---|---|---|---|
| Recovered | 3 (4%) | 7 (8%) | 18 (21%) |
| Much Improved | 22 (26%) | 22 (26%) | 33 (40%) |
| Improved | 38 (45%) | 32 (38%) | 19 (23%) |
| Unimproved | 18 (21%) | 18 (21%) | 13 (15%) |
| Worse | 3 (4%) | 5 (6%) | 1 (1%) |

At the end of the four months' period of investigation, the recovery rate was 30 per cent, and the unimproved rate was only 10 per cent.

It must be mentioned here that the results four weeks after commencement of therapy should have been better than indicated in Table III. This statement is based on the fact that several patients who initially improved relapsed when therapy was interrupted after approximately two weeks, and again improved when therapy was resumed; the period of interruption of therapy was usually just a few days, or two weeks at the most. Thus, the four weeks' scores reflect these patients' condition just after therapy had been resumed, before the full effect was obtained. At the beginning of this investigation, we decided to discontinue therapy if the patients had shown a good response within two weeks. Many of these patients subsequently relapsed within the following two weeks; hence they were given a second and usually longer course, to which they usually responded within a few days.

Three patients did not improve while receiving Imipramine (G 22355), but subsequently improved with E.C.T.

The optimum time for discontinuing therapy has not yet been determined. Several patients maintained their improvement with only 2-3 weeks of therapy, while most patients in our series required at least a month of therapy, and some seem to require maintenance therapy for as yet an indefinite period of time.

A further breakdown according to diagnostic categories shows that the best results were obtained in patients diagnosed as having endogenous depressions; about three-quarters of these cases were judged recovered or much improved. Patients with diagnoses of neurotic depressive reactions responded less favourably, as was to be expected. Of the eleven patients whose diagnosis was schizophrenia or schizo-affective psychosis, and who were treated because depressive elements were present in their condition, none recovered, four were much improved, six were improved, and one was worse.

Of 19 patients with chronic endogenous depression, nine recovered or were much improved, and only three were unchanged; eleven of this group had been found to be refractory to E.C.T., and of these four were much improved and five improved. On the whole, our results were similar to those reported by Kuhn; 75-80 per cent of his 300 patients improved, those with endogenous depressions showing a better response than depressed schizophrenics, neurotics, and others.

**Results of Double-Blind Experiment**

Of the patients on placebo, ten became worse, eleven did not. Of the patients on active drug, three became worse, and 17 did not (one dropped out for administrative reasons). This difference is significant statistically ($<0.05$).

Of the three patients who became worse while receiving the drug, one was diagnosed 'Inadequate Personality with Depressive Features' and had a previous history of frequent fluctuations of mood; the other two were both typical 'chronic schizophrenics' who at the time of initial selection for therapy with the drug, had some depressive features. All of the ten patients who became worse on placebo improved within two weeks of resumption of therapy with the active drug. None of the patients who remained improved or unchanged while receiving placebo, became worse afterwards.

**Side Effects**

A variety of side effects was encountered in about one-third of all patients treated.

Cardiovascular and vasomotor symptoms were the most frequent, comprising eleven cases of syncope or hypotension and one case of dyspnea and cyanosis, the latter promptly relieved by a reduction in dosage from 200 to 100 mgms daily. One case of fatal myocardial infarction in the series may possibly have been related to the drug, although there was no direct evidence of this. This patient was showing an excellent clinical response to Imipramine (G 22355) when, on the twentieth day of treatment, he died suddenly while eating his supper.

Other serious side effects included epileptiform seizures in two patients (one of these had a past history of epilepsy, while the other had a characteristic EEG). Diplopia occurred in two other patients, jerky tremors in six, and involuntary staring was noted in four. None of the patients developed extrapyramidal symptoms of the akinesia or akathisia type, but one case of dystonia with a marked lordosis was probably of extrapyramidal origin.

Psychiatric complications included visual hallucinations in five cases, increased agitation in three, and a shift to hypomanic excitement in two.

Less serious symptoms such as tremor, increased sweating, and dry mouth were fairly common, and in many cases, were not considered worth reporting by the affected patients.

One out-patient (not included in this series) developed asymptomatic jaundice but recovered from this in about ten days after Imipramine (G 22355) was discontinued. Kuhn also reports two cases of transient jaundice in his series of 300 cases.

We did not observe the photosensitization which Kuhn described in his patients (ours may have been protected by a period of weak sunlight), nor were other dermatological complications reported in this series.

Spot tests of blood urea nitrogen, alkaline phosphatase and serum bilirubin, as well as routine analyses of blood and urine, were performed on a number of patients throughout the period of investigation and did not reveal any deviation from normal. This is also in accord with Kuhn's findings.

In our analysis of the group suffering from side effects, age and dosage were found to be contributory factors.

Of the 20 patients aged over 65, more than half had side effects (compared with the incidence of one-third in the total group).

Serious side effects could have been practically eliminated except in elderly patients if the daily dose of Imipramine (G 22355) had been kept below 200 mgms, and when side effects did occur they tended to be promptly relieved by stopping or decreasing the drug.

It is our impression that a daily dosage below 200 mgms is sufficient, except in a few cases, to produce optimum therapeutic benefit, although the rate of improvement may be somewhat slower.

## Discussion

The first question a clinical investigator of a new drug must ask himself when looking at his results deals with the grounds for his assumption that these results are attributable to the pharmacological effects of the drug and not to incidental and environmental factors. In our case this assumption is based on two lines of evidence.

First, our clinical judgment indicated that the proportion of patients significantly improved following the administration of the drug was greater than could have been anticipated as spontaneous improvements occurring in the natural history of the illness or as placebo effects. Many of the patients had been chronically ill and had failed to respond to other treatments, and most acute cases under treatment improved in a shorter time than is usually observed in endogenous depressions left to their own resources. Patients suffering from endogenous depressions are known to be particularly resistant to placebo effects.

Secondly, our double-blind technique brought out a higher relapse rate of patients on placebo than of patients on the active drug. This difference was statistically significant.

Although we can be reasonably sure that the degree of improvement shown by our depressed patients on this drug in a given time was greater than could have been expected without a drug or with an inactive substance, we are unable at this stage to express any opinion on the specificity of the pharmacological action of Imipramine (G 22355). It is conceivable that similar results might have been obtained with other drugs. We are simply reporting our results with this drug as they were observed in our systematic study of its action on depressed patients.

Our findings indicate that this substance is of value in the treatment of depressed patients. It should be noted, however, that the effects of the drug are much less spectacular than the therapeutic action of electroconvulsive treatment as regards both immediacy and intensity of its results. A deeply depressed patient who is suicidal might still require electroconvulsive therapy in order to control the situation rapidly, particularly if the patient is not hospitalized. In the setting of a closed hospital we were able to give effective relief to most of our depressed patients with the drug alone, even if they were greatly disturbed. There are certain advantages to a therapeutic regime without electroconvulsive treatments. On the other hand, psychiatric tolerance to depressive symptoms in patients has been so much reduced during the last fifteen years that many psychiatrists may find it difficult to wait two to four weeks before seeing a definite lifting of depression in their patients.

Imipramine (G 22355) has to be given for some time after most symptoms have subsided and, including this maintenance therapy, the treatment period may often be longer than with electroconvulsive treatment. The fact that some patients seem to develop tolerance to the drug and that it produces no particularly unpleasant side effects raises the question of possible addiction, a question that we can not answer at the present time other than by stating that we did not observe any tendency for any patient to become dependent on the drug, nor any withdrawal symptoms in our group of patients.

A brief discussion of the term 'depression' might be in place here, as the varying use of this diagnostic term by different authors has at times caused some semantic confusion. It is perhaps unfortunate that the term 'depression' is used by physiologists and by psychiatrists in quite a different sense. The physiologist refers to depression as a simple reduction, a passive partial loss of function, as in circulatory and respiratory depression. The psychiatrist, on the other hand, when he speaks of depression as a diagnostic category refers to a

complex state of highly organized emotional and ideational processes which are characterized by the quality of their special configuration, rather than by their reduced level of intensity. In fact, many vital processes of the patient in a state of psychiatric depression are often greatly heightened in intensity (14, 19) e.g. reflex irritability, blood pressure, adrenocortical activity, basal metabolism, affective tone, level of arousal, even if we are dealing with a patient in a retarded and not in an agitated depression.

By confusing the apparent lack of energy of the patient in a psychiatric depression with the true energy deficit which exists in patients whose functions are depressed in the physiological sense of the term, the misleading notion of 'energizers', i.e. agents which make available additional energy for the psychiatrically depressed patient, has developed. This notion is misleading because a freeing and redirection of energy is needed in the psychiatrically depressed patient, rather than an additional supply of it. The whole concept of psychic energy is far from clear, as we have pointed out in a previous publication. (14)

The foregoing remarks apply only to the special category of depressed patients such as we have selected for a therapeutic trial with Imipramine (G 22355). Since other types of psychiatric patients have sometimes been included in the diagnostic classification 'depression', we propose the following subdivision of psychiatric patients who are all characterized by the common denominator of reduced spontaneity. If we accept to refer to all such patients as 'depressed', we would have to distinguish between the depression of the patient in *coma* and *sopor*, who is on the lower end of the scale of arousal, the *asthenic depression* of the patient with a true reduction of vital energy as in fatigue and exhaustion states, the *apathetic depression* of the patient with a primary lack of drive as in some inert schizophrenics, the *catatonic depression* of the patient with cataleptic symptoms or withdrawal due to a defensive inhibition of drive, and finally, the *dysphoric depression*. Dysphoric depression is the only type we have considered in our therapeutic trial, i.e. the psychiatric depression characterized by an affect of despondency, bitterness or morbid guilt, and the corresponding physiognomic, behavioural and ideational manifestations.

It is interesting to note that the iminodibenzyl derivative which we employed is characterized by its primarily inhibitory or depressing (in the physiological sense) action on the central nervous system. Iproniazid, another therapeutically effective agent in depressive conditions, is a drug with mainly excitatory action on the central nervous system. It is not surprising that sedative as well as stimulant drugs may be effective in a psychiatric depression of the dysphoric type, if one keeps in mind that this is a complex condition and not simply the result of global inhibition or excitation of the C.N.S. One could speculate that some particular regulatory center, probably subcortically located in the brain, is either pathologically inhibited, depressed or excited in relation to the surrounding neuronal field, and that a therapeutically effective drug restores the disturbed equilibrium of excitatory gradients either by direct influence on the disturbed focus, or indirectly, by acting on the surrounding cerebral field; hence it may have either inhibiting or exciting properties. Such a speculation can not be substantiated at this time, and is only offered as a possible conceptual model.

Considering the biochemical properties of Imipramine (G 22355) as contrasted to iproniazid, one notes that Imipramine (G 22355) has an appreciable anti-serotonin action, while iproniazid through its inhibition of the enzyme monoamino-oxidase probably increases the serotonin level in the brain. (20, 21) This increase of cerebral serotonin has been proposed as an explanation for the anti-

depressant effect (in the psychiatric sense) of iproniazid. If this theory is correct, it follows from the therapeutic action of Imipramine (G 22355) that other mechanisms must be involved, as well, in the effective treatment of psychiatric depressions of the dysphoric type.

**Summary**

1. Imipramine (G 22355) is a new chemical agent with a primarily inhibitory action on the central nervous system. It has definite anti-depressive properties in the psychiatric sense, producing a gradual lessening and frequently a disappearance of the symptoms and signs of depressive states.

2. Of 84 patients with various psychiatric diagnoses who had in common the presence of symptoms of dysphoric depression, 30 per cent recovered or were much improved after two weeks, and 60 per cent recovered or were much improved after eight weeks of therapy with Imipramine (G 22355); a further percentage showed lesser degrees of improvement. These findings correspond fairly well to the results reported by Kuhn in 300 patients, viz. improvement in three-quarters to four-fifths of his cases.

3. The results in depressed patients with neuroses, schizophrenia, and organic conditions were less favourable than in patients with endogenous depressions.

4. The frequency of side effects was low, but increased when the dose was over 200 mgms. daily, especially in patients over the age of 65. Side effects were expressed mainly in disturbed functioning of the autonomic nervous system, although there were also a few cases of toxic confusion, two cases with epileptiform seizures, and one case of mild transient jaundice. There was one death in our series, probably due to acute coronary occlusion and apparently not related to the drug.

5. A rating scale for the rapid and effective assessment of depressive symptoms is described, and the results of a 'double-blind' experiment are discussed.

6. The concepts of physiological and psychiatric depression are discussed and several clinical categories are differentiated in order to clarify the use of the term.

7. It is concluded that Imipramine (G 22355) is a relatively non-toxic drug useful in the treatment of depressions, especially of the endogenous type.

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**Résumé**

1. L'Imipramine (G 22355) est un nouveau produit chimique qui exerce, avant tout, une action inhibitrice sur le système nerveux central. Il manifeste des propriétés antidépressives (dans le sens psychiatrique) qui se caractérisent par une diminution progressive et souvent par une disparition totale des signes et symptômes des états dépressifs.

2. Sur un nombre de 84 patients ayant différents diagnostics psychiatriques mais présentant en commun des symptômes de dépression dysphorique, il a été observé un rétablissement complet ou une amélioration considerable dans 30% des cas après deux semaines et dans 60% des cas après huit semaines de traitement par l'Imipramine (G 22355). Une amélioration moins importante a été obtenue dans un pourcentage additionel. Ces résultats concordent assez bien avec ceux rapportés par Kuhn qui obtint une amélioration des ¾ à ⅘ d'un nombre de 300 patients.

3. Les meilleurs résultats ont été obtenus chez les patients présentant une dépression endogène. Mais quand la dépression était associée à une névrose, à la schizophrenie ou à une condition organique, la réponse était moins favorable.

4. Les effets secondaires étaient rares mais devenaient plus fréquents lorsque la dose dépassait 200 mgs par jour, particulièrement chez les patients agés de plus de 65 ans. Ces effets se manifestaient par des troubles du système nerveux autonome; mais, en outre, il a été aussi enregistré quelques cas de confusion d'origine toxique, deux cas de crise épileptiforme, un cas d'ictère léger et passager et un décès problablement du à une occlusion aigue coronarienne et apparemment non attributable à l'action du médicament.

5. Un système rapide et efficace d'évaluation des symptômes dépressifs a été employé, et les résultats ont été compares à ceux obtenus par l'emploi de administré a l'insus des investigateurs.

6. Les concepts de dépression physiologique et psychiatrique sont discutés et une différenciation de plusieurs catégories cliniques a été entreprise en vue de clarifier l'usage du terme.

7. En conclusion, l'Imipramine (G 22355) est un médicament relativement non-toxique et efficace dans le traitement des dépressions particulièrement du type endogène.

# MARITAL COUNSELLING*

F. G. Coburn, M.D.[1]

In almost any type of psychiatric work it soon becomes apparent that marital disharmony is a major factor in human unhappiness, both for the couples involved and because of its effect on their children. This paper is a preliminary report on certain aspects of therapeutic intervention designed to ameliorate the distress many couples have and thus to improve their mental health and the mental health of their children. This is not intended as an exhaustive or definitive study of marriage counselling, nor is there any claim made that the answers to all problems are known. It is hoped that this discussion will stimulate others to experiment with this or other techniques in this area of psychiatric counselling.

**Selection of Cases:**

Using the method to be described, it is important that the type of cases be carefully chosen. The situation must be one in which both partners are interested in preserving their marriage and in which each is willing to accept some responsibility for the problem rather than blaming it all on the spouse. Both parties must be willing to co-operate and be accessible for therapy. Neither should be suffering from mental deficiency, psychosis or one of the neurotic syndromes. In the latter case – the clearly neurotic – longer individual therapy is indicated.

**Therapeutic Principles:**

There are three basic principles involved. The first is that each member of the marriage couple comes into marriage with certain emotional needs, and that if these needs are not met in the marriage, unhappiness will result. These emotional needs arise out of life experiences of the individual. In marriage they want the continuation of those emotional experiences which where satisfying in their parental homes and an avoidance of those situations which were distressing.

Another basic concept is that our attitudes to the opposite sex are largely determined by our relationship to the parent or parent substitute of the opposite sex. From our fathers we learn our attitudes to men and from our mothers to women. This attitude developed toward our parents tends to be generalized toward all members of the opposite sex, although it may not be valid in our relationships with different personalities.

The third basic concept is that all of us come into marriage with an idea of the husband's role and the wife's role which is based on the experience of the marriage we have known most intimately, that is the marriage of our parents. We may be accepting of the roles which our parents played or rejecting in some aspects or in all. Now since each one of the couple have been exposed to a different set of parents, it is obvious that each has a different concept of their own role as well as their partner's. A certain amount of disappointment and re-adjustment is therefore inevitable in every marital relationship.

**Method:**

These basic principles are put to use as follows allowing some variation in individual cases.

As a rule both partners are seen together at the first interview and asked to discuss the problems of their marriage. This joint interview serves as a screening process to see whether the method is applicable, whether both members

*Presented at Canadian Psychiatric Association Meeting, Edmonton, 1957.
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are anxious for a solution and whether each will accept his or her share of the responsibility. The joint interview also gives the therapist insight into the role each person is playing in the marriage; who is dominant, who is passive, who is parental, who the dependent child, etc.

After the problem has been delineated the therapist takes over with an explanation of the method to be used. It is outlined much as above – that each have emotional needs that are not being met, that these needs arise out of their parental homes, that each has an idea of their marital role and that possibly neither one has the same idea. The therapist then proposes to discuss with each partner individually their background; discover their emotional needs and with permission let the other partner in on what he discovers. This last point is vitally important – that each one recognize that the therapist's conclusions will be passed on to the partner and solid agreement on this must be achieved before proceeding.

The next step in the treatment consists of a number of interviews with each of the partners, usually about four apiece. In these interviews a straightforward anamnesis is taken with special reference to relationships of the patient to both parents and the relationships between the parents themselves. Particular emphasis is laid upon the system of communication between the parents, particularly the dominance and submission, handling of money and sex relations of the parents, if known. Attention is directed in the life history to the patient's relationship to other people prior to marriage, particularly to people of the opposite sex, and finally sexual experiences and attitudes are discussed.

Throughout the process, an attempt is made to keep some focus of the goal on marital harmony by tentative interpretations of the effect which events told by the patient might have on attitudes in marriage. Toward the end of this series of interviews, the patient's attention is directed to his or her knowledge of the family background and life experience of the spouse, with an attempt being made to understand the emotional needs of that person. The reason for the partner's "excessive needs" which are usually not excessive in the light of life experience are explored. Concomitantly the patient is helped to recognize where his needs may appear excessive to the partner. Gradually this exploration of the partner's background by the patient is amplified by the therapist in light of his interviews with the other person.

The marital relationship is reviewed again with each partner separately in light of the new insight discovered during the interviews. The patient comes to recognize where his or her own needs come from and whether some of them are not valid or realistic and where the partner's needs come from and what must be done to provide emotional satisfaction to the partner. At this time some stress is laid on the difficulty each has had in knowing what the other one needs and the difficulties arising out of problems in communication. Each person is encouraged to express the emotional reactions to the other so that the disturbing actions and attitudes can be corrected rather than producing increased resentment.

As outlined above, this sounds like a rather sterile intellectual approach but in practice it proves to be quite the reverse. Patients are usually quickly emotionally involved. They get much satisfaction out of the insight into themselves that comes from an analysis of their attitudes derived from the parents, and the transference of these attitudes to the spouse. It tends to relieve the guilt feelings to realize that there is a cause for their own behaviour other than that they are simply unpleasant people. The recognition that their attitudes towards their spouse is a transference at least in part frequently relieves them of

doubt regarding the wisdom of their marriage. No attempt is made to probe the deeper levels of the psychosexual relationship with the parents. This would appear necessary only if the patient were quite neurotic and these are excluded from this type of counselling.

Finally another joint interview with both partners is held and the material from both is reviewed. This is necessary to minimize the distortions which each person might make and to increase the likelihood that both partners will have the same understanding. Frequently this interview gets around to discussion of the practical applications of these insights. The therapist encourages this and also encourages the couple in the process of expressing their feelings to one another and working out solutions rather than accepting any solutions suggested by the therapist. The couple are then dismissed with the invitation to return together if they feel the need for further help.

**Example:**

A physician and his wife, both aged 32, married four years, came on self-referral because of unhappiness and their constant quarrelling and threatened separation. They both admitted that they were irritable with one another, lost their tempers and said things they did not mean in an attempt to hurt the other person. At the same time they agreed that the other partner was a fine person of whom they were very fond and whom they respected. She complained that they never did anything together, that he did nothing around the house and that when they quarrelled he turned to his family for support. His complaint was the she nagged him continually, did not allow him to rest and was a poor housekeeper. They agreed that their sexual relationship was satisfactory except that when they quarrelled he would attempt to terminate the altercation with intercourse and she at that time was not accepting. The husband was a busy physician establishing himself in his small home town. The father was also a physician in the same place. Throughout the boy's childhood the father had been the only doctor in town and extremely busy. The father allowed himself no recreation or social life, at least when the boy was young. When not in the office, at the hospital or on house calls, he came home and collapsed in an easy chair. The boy's mother at these times waited on the father and relieved him of all domestic responsibility. She assumed care of the furnace and lawn, put on the storm windows, etc. Rather early in life the boy identified himself with his father, planned to be a physician like his father, was not made to share any of the domestic tasks which his mother discharged. The mother, though very protective of the father, was a rather dominant person who tried to control both father and son in many aspects of their lives. The boy felt that his father was henpecked and had resolved consciously not to be so himself. His wife came from the Eastern seaboard to the West to marry the young doctor, having met him when he interned in her city. Her mother was dead, having died when the girl was 22 after prolonged invalidism from multiple sclerosis. From the time she was six her mother had been restricted, at first to a wheel chair and then to bed. Her father was a successful manager of his own business. He was devoted to his wife and only child. His pattern was to rise early, prepare breakfast for the wife and child, make the wife comfortable for the day and get the girl off to school before leaving for work. He left lunch prepared to be served by the girl. In the evening he returned and got dinner ready and then with some help from the daughter did the housework. The girl's relations with both parents was quite close but because of her mother's illness she had to depend on her father for many things for which a girl usually turns to her mother, e.g. choice of clothing, etc.

The conflict of the spouses in marriage is obvious. Both of them had been used to a parent of the opposite sex who assumed almost all the domestic responsibility. Both were overly dependent and were not meeting the dependent needs of the other. In addition, the husband was afraid of being dominated by a woman as his mother dominated him and his father, and the girl 2,000 miles away from her protective father felt threatened by her husband's family to which he turned in times of stress and which sided with him against her.

During the individual portions of their treatment, both came to realize the nature of their excessive dependency and both had strong enough personalities to accept that the pattern in which they had been raised was abnormal and could not continue in adult life. At the same time each recognized the need of the other for some support similar to what they had experienced in childhood; she, seeing that her husband was tired in his free time and in need of rest, and he accepting that his father's role in the domestic situation was not the usual division of labour in the family. Furthermore, he recognized that his passivity led to the dominance he detested and to the nagging on the part of the wife to get done the things which needed to be done and for which she was untrained. In their final joint interview in the scheduled series, there was an apparently ungrudging acceptance of these facts. Agreement was reached that he would give up an extra professional responsibility he had taken on, freeing him to be of some help in domestic matters and that he would hire things done for which he was realistically too busy. At the same time there was agreement reached that she should not call on her father for help in time of emotional tension, nor that he should turn to his family.

The result was not immediate marital bliss but there was considerable improvement. The deeper conflict over the need for more dependent satisfaction than the partner was willing or able to give continued and the couple were seen four times in the ensuing year in which period there was a gradual diminution though not complete elimination of this problem.

**Summary**

1. A method of marital counselling of "non-neurotic" couples is described.
2. The couple are interviewed together at the beginning and ending of the series and separately the rest of the time.
3. The principles involved:
   (a) The emotional needs of each in marriage arising out of relationship to parents.
   (b) The role of the marital partner is learned by observation of parents.
   (c) The relationship to people of the opposite sex is determined largely by the relationship to the parent of the opposite sex.
4. These aspects are explored for each partner and then by agreement imparted to the other.
5. Stress is laid on communication of difficulties to allow for settlement and avoidance of resentment.

**Résumé**

1) Une description est donnée d'une technique pour diriger les couples non-névrotiques dans leurs difficultés conjugales.

2) Les conjoints sont vus ensemble au début et à la fin de la série d'entrevues et séparément le reste du temps.

3) Cette méthode repose sur les principes suivants:

a) Les besoins émotionnels de chacun des conjoints dans le mariage tirent leur origine du type de leurs relations avec leurs parents.

b) Le rôle d'époux est appris de l'observation des parents.

c) La façon d'établir des relations avec les personnes de l'autre sexe est déterminée largement par le genre de relations qui a existé avec le parent du sexe opposé.

4) Ces divers aspects sont étudiés avec chacun des conjoints et après acceptation communiqués à l'autre.

5) On insiste sur l'importance de se faire part entre conjoints des difficultés dans le but de faciliter la découverte d'une solution et d'éviter tout ressentiment.

## INTERNATIONAL STUDY OF PSYCHOLOGICAL PROBLEMS IN GENERAL HOSPITALS

### INTERNATIONAL COUNCIL OF NURSES
### INTERNATIONAL HOSPITAL FEDERATION
### WORLD FEDERATION FOR MENTAL HEALTH

Many studies, surveys and research projects of all kinds concerning mental hospitals, children in hospital, relations in industry and other organized communities have been carried out in many parts of the world, but so far there have been very few concerning general hospitals—and even fewer undertaken by general hospital personnel themselves.

The sponsoring organizations believe there is a need for such a study and early this year asked their Member-Associations in the following countries to take part:—

BELGIUM, CANADA, DENMARK, FINLAND, FRANCE, GERMANY, HOLLAND, NORWAY, SWEDEN, SWITZERLAND, UNITED KINGDOM, UNITED STATES.

The general plan is to bring together members of the various hospital professions and trades, psychiatrists and social scientists, ex-patients and their relatives, to form small discussion groups and to study the routine situations and chance happenings which affect the relationships and mental health of people in hospital.

Psychological discussion tends to become academic rather than realistic unless based on actual situations and personal experience. The people needed to carry out the study, therefore, are those with current experience of general hospitals.

The work of finding such people is being undertaken by the *Member-Associations* of ICN, IHF and WFMH, who have formed steering committees or appointed study organizers.

In some countries, discussion groups have already begun work. Study programs are being determined largely by local and national interests and needs. Groups have each been asked to produce interim reports and a final report by July 1959. These final reports will be used by an international group of experts who will probably meet in 1960, World Mental Health Year.

It is hoped finally to produce a publication, suitable for translation into several languages, for the use of hospital personnel in all countries. The study has already resulted in closer collaboration of people in the hospital administrative, medical, nursing and psychiatric disciplines, by providing them with a common basis for discussion. It may also lead to more research in general hospitals. But perhaps its most important result will be a greater awareness by general hospital personnel of the principles of positive mental health and their application in the everyday life and work of general hospitals.

The study is supported by the Grant Foundation, New York, and is being co-ordinated from WFMH headquarters, 19 Manchester Street, London, W.1., U.K., by Miss Elizabeth Barnes.

# LEUCOTOMY — ITS THERAPEUTIC VALUE ON THE DISTURBED WARDS OF A MENTAL HOSPITAL*

B. A. Boyd, M.D.**, W. H. Weber, M.D.**, K. G. McKenzie, M.D.***

## Introduction

The Ontario Hospital, Hamilton, cares for 1,760 mentally ill patients. Approximately 15% of these patients require confinement in special wards for disturbed patients. In the Province, 19,000 patients are confined in Ontario hospitals. No doubt these other hospitals have similar problems with the disturbed patient. Many of these patients have not responded favourably to psychotherapy nor to electroshock and insulin-coma therapy, and have failed to show spontaneous improvement. Many are chronically disturbed, miserable in themselves, and a great problem to those who care for them.

## Project

Because of this problem, it was felt that there was need for a Leucotomy program which concentrated on the disturbed patients who present a difficult nursing problem, not so much to get patients out of hospital as to relieve the overall nursing problem. Thus, the Leucotomy program which commenced in the Ontario hospital, Hamilton, in June, 1952, differed from most Leucotomy programs, where emphasis has been placed on selection of patients in whom there was reasonable hope of improvement, so that they could leave hospital. Primarily, we wished to find out if these arduous nursing tasks could be alleviated by bilateral Leucotomy. This paper is based on the first 60 consecutive patients in this highly disturbed difficult nursing group, although reference will also be made to the overall series of 200 patients. Such patients typically were confined to a disturbed ward, frequently in single room seclusion. They were destructive, noisy and assaultive, and often required supervision in their eating, dressing and toilet habits. They were unable to mix with other patients or do consistently useful work on the ward. Often they received symptomatic electro-convulsive therapy. 78% had been in hospital over 5 years. 93% had been ill over 5 years.

## Anaesthesia

Sodium Amytal grs. 111, orally and Atropine grs. 1/100 intramuscularly are given one hour in advance. Anaesthesia is accomplished by the combined use of intravenous pentothal and 1% novocaine infiltration of the scalp incision.

A 2½% solution of pentothal containing d-turbocurarine, 12 mgs/Gm for the female patient, 15 mgs/Gm for the male patient, is administered intravenously in amounts just sufficient to stop the patient from moving during the operation. Average doses of pentothal required are 0.75 Gms: maximum and minimum are 1.2 Gms. and 0.4 Gms. respectively. In the majority of cases these patients are reacting as they leave the operating room; some have returned to the ward without signs of awakening, but there have been none requiring administration of oxygen after return to the ward. Oxygen is delivered via an oral hook at the rate of 5 litres per minute. An adequate airway is maintained by manual support of the jaw. The operation is completed in 20 or 30 minutes.

An interesting observation during this series of cases, has been the quiet behaviour of the patients before operation. In only four cases has restraint been necessary while shaving the scalp or in the operating room prior to the administration of the anaesthetic, yet these patients are all accustomed to sedatives much in excess of their pre-operative dose.

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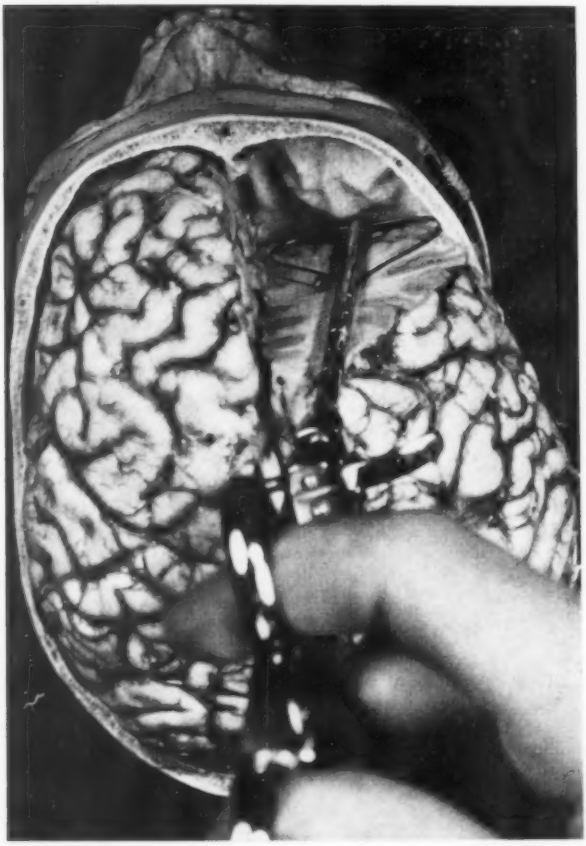
Leucotome, with plunger depressed and cutting wire extruded. Withdrawal of the plunger returns the wire, thus enabling the operator to withdraw the instrument through a small cortical puncture wound.

### Neuro-Surgical Technique

A comparable standard technique has been carried out on all patients, utilizing a leucotome* (Illus. 1) devised to make a cut through the white matter of the frontal lobes 4 to 5 cm. in diameter. A burr hole is made about one inch from the midline on each side. From before backwards the burr hole is directly over the surgeon's imaginary visualization of the posterior margins of the supra orbital plates and just in front of the anterior horns of the lateral ventricles. After the dura is opened, a small area of cortex is coagulated and punctured. A brain needle is then inserted and the central portion of the posterior margin of the supra orbital plate is palpated. The needle is withdrawn and the unopened leucotome is inserted along the same line and brought to rest impinging on the posterior margin of the supra orbital plate. The plunger of the leucotome is then depressed and the wire loop is extruded, making a cut 4-5 cm. in diameter in the white matter of the frontal lobes (Illus. 2). The plunger is withdrawn, pulling the wire back into the instrument, which is then withdrawn through

*Developed in 1945 with the assistance of Mr. E. Scherle of the J. F. Hartz Co., Toronto.



A dissection to show the position of the opened leucotome in relation to the white matter of the frontal lobe.

the small cortical puncture wound. Finally, using a brain needle which gives a surgeon a sense of feel the intra-cerebral cut is enlarged medially – during this procedure the falx can be palpated and often the end of the blunt brain needle can be felt slipping over the anterior cerebral artery. The dural openings are covered with a piece of polyethylene membrane and the burr holes filled with bone dust to prevent a deforming depression.

As one gains experience with this technique, it is fair to assume that most of the cuts are symmetrically placed just in front of the anterior horns of the ventricles and they do not extend down into the dangerous third ventricle region. We have had an occasional major haemorrhage and a mortality rate from this cause of approximately 1%, caused we feel by attempting to enlarge the cut by manipulation of the leucotome after it is opened. There have been no major haemorrhages since we have stopped this and used a brain needle to enlarge the mesial parts of the leucotomy cut.

We have considered it advisable to make a smaller cut in certain patients; this is accomplished with a leucotome which extrudes the wire only from

one side. In all patients considered in this paper, the leucotome which is shown in Illus. 1, has been used.

**Post-Operative Status and Care of the Patient and Complications**

The majority of patients are up within a day. Practically none has presented nursing problems in this period. After about a week the patient is returned to his own ward.

In the overall series of 200 patients, four have developed cerebral haemorrhages at operation, presumably from branches of the anterior cerebral artery. Two of these cases died 8 days after operation. The other two have shown no residual damage. There has been no case of infection, either in the wound or intracranially.

Two years ago when this series had reached 100 cases, four cases had developed epilepsy. The seizures in these patients were rare and easily controlled by anti-convulsant medication.

Also in the first 100 patients, 8 developed incontinence after operation, but this cleared up within 3 months in all but one patient who still wets, especially at night, unless toileted every several hours.

**Selection and Assessment**

Each patient's case was summarized and discussed in staff conference, when it was decided whether to operate and what results were to be expected. A scale (Table A) of social adjustment devised at the Toronto Psychiatric hospital was used. On this scale, points range from 0 to 100, depending on success in social adjustment. From 0 to 30 represent patients requiring hospital care. Particular attention was paid to the nursing problem due to destructiveness, assaultiveness or noisiness. The post-operative results were assessed at intervals by one of us (Boyd). In addition the opinion of the relatives and the ward nursing or attendant staff who actually cared for the patient both before and after the operation was considered particularly important. We consider it of

TABLE A: SCALE OF SOCIAL ADJUSTMENT

IN HOSPITAL

| 0 | 10 | 20 | 30 |
|---|---|---|---|
| Nursing Problem | No Nursing Problem | No Nursing Problem | No Nursing Problem |
| No Self Care | No Self Care | Self Care | Self Care |
| No Work | No Work | No Work | Working |

OUT OF HOSPITAL

| 40 | 50 | 60 | 70–80–90–100 |
|---|---|---|---|
| No Work | No Work | Some Work | Intellectually |
| Supervised | No Supervision | Supervised | Socially |
| | | | Emotionally |
| | | | Occupationally Normal |
| | | | 10 Points Each |

Table A, devised at the Toronto Psychiatric hospital, shows a scale rating of Social Adjustment.

TABLE B: BEHAVIOUR PROBLEMS THAT MADE NURSING DIFFICULT
(60 Patients)

| | Before Operation | After Operation |
|---|---|---|
| Were Destructive | 35 | 10 |
| Were Assaultive | 51 | 21 |
| Were Noisy | 47 | 19 |
| Required Self Care | 29 | 16 |
| Had Poor Eating Habits | 23 | 11 |
| Were Unsociable | 51 | 39 |

Table B, shows the effect of Leucotomy on nursing problems.

some importance that patients were returned to their original ward. Any change for better or worse could then reasonably be attributed to the operation. If sufficient improvement occurred, they were later transferred to a less disturbed ward.

**Results Following Operation**

Table (B) shows the number of patients considered to be a problem due to destructiveness, assaultiveness and noisiness. It shows the number who required supervision in self care and eating habits, and the number who were unable to mix with other patients. Of the 60 patients, 10 were two years post-operative, 44 were one year post-operative and 6 were six months post-operative. 41 patients are women; 19 are men.

From this table certain trends are apparent.

Destructiveness has been reduced by over ⅔, more in men than in women. This has meant a considerable saving to the hospital in clothing, bedding, mattresses, dishes and window panes. Most of this improvement was apparent within the first 6 months.

Noisiness has been reduced by ⅔, equally in men and women.

Need for supervision in self care has been reduced only ⅓, more in men than women.

Need for supervision in eating habits has been reduced about one-half, more in men than women.

Lack of sociability as a problem has been reduced only slightly in either sex, although rather more in men than women. Most patients continued solitary, seclusive lives, in spite of encouragement to mix with others.

TABLE C: PATIENTS REQUIRING CONTROL BY ELECTRO-CONVULSIVE THERAPY AND SINGLE ROOM SECLUSION
(60 Patients)

| | Before Operation | After Operation |
|---|---|---|
| Required Seclusion | 45 | 18 |
| Required Electro-Convulsive Therapy | 39 | 11 |

Table C, shows the effect of Leucotomy on need for seclusion and electroshock therapy.

Table C shows the number of patients requiring single room seclusion and the number requiring symptomatic electro-convulsive therapy.

The number of patients requiring seclusion has been reduced by ⅔. Most of those who still require seclusion now need it only rarely and for short periods, rather than constantly. This has enabled the staff to intensify efforts at socialization and occupational therapy for these patients.

The number of patients receiving symptomatic electro-convulsive therapy dropped more than ⅔, more in men than women. This has caused an enormous saving in staff time.

It is interesting to note that in most cases, the maximal improvement was reached within 6 months. The results at 2 years are from too small a group (10) to have much validity.

Our disturbed women's ward in the month of March, 1952, used 609 doses of sedative. In March, 1954, this figure dropped to 372. During this time there was no factor other than leucotomy to account for the change.

Six months after operation, 15% of these 60 patients were out of hospital, at home or in boarding-out homes. This figure remained at 15% (of 54 patients) at one year, rose to 30% (of 10 patients) at two years. At present, 13 of the 60 patients (22%) are out of hospital. This marked improvement has been a pleasant surprise to the staff.

### Relationship Between Diagnosis, Length of Illness and Age, and Results

The whole group of 60 patients was divided into three groups, those 20 with best results, those with worst, and those between.

Table D shows the relation between degree of success and duration of hospitalization and illness. This indicates that those patients in hospital over 5 years did as well as those in hospital less than 5 years, and that length of illness over 5 years had very little if any deleterious effect.

Table E shows the relation between degree of success and diagnosis. This table suggests that the best results were obtained in Manic and Paranoid cases, where personality is best preserved and affect is strongest. The results with Catatonic Schizophrenics were less uniform.

The median ages of the best, middle and worst groups of 20 are 41, 40½ and 40 respectively, indicating no significant relationship between age and results.

The results with men have tended to be better than those with women. The best group of 20 included 44% of the men and 29% of the women.

### Predictive Accuracy

Before operation a prediction was made as to the probable level each patient would reach on the scale of social adjustment. The various factors which

TABLE D: RESULTS AND LENGTH OF ILLNESS

| | In Hospital Over 5 Years | Ill Over 5 Years |
|---|---|---|
| Whole Group (60 Patients) | 47 (78%) | 56 (93%) |
| Best Third (20 Patients) | 15 (75%) | 17 (85%) |
| Worst Third (20 Patients) | 15 (75%) | 19 (95%) |
| Middle Third | 17 (85%) | 20 (100%) |

Table D, shows the effect of length of illness on prognosis with Leucotomy.

TABLE E: RESULTS AND DIAGNOSIS

| Diagnosis | Best Third | Middle Third | Worst Third | Total |
|---|---|---|---|---|
| Manic | 6 | | 1 | 7 |
| Paranoid State | 1 | 1 | | 2 |
| Paranoid Schizophrenia | 4 | 6 | 2 | 12 |
| Catatonic Schizophrenia | 8 | 11 | 13 | 32 |
| Simple Schizophrenia | | 1 | | 1 |
| Psychosis with Deficiency | 1 | 1 | 2 | 4 |
| Mental Deficiency | | | 2 | 2 |
| | | | | 60 |

Table E, shows the relation between diagnosis and prognosis with Leucotomy.

were considered in particular in arriving at a prognosis were: preservation of personality, strength of affect, variations in mental state with periods of relatively normal behaviour, and the presence of an interested family.

Table F shows the predicted score and the actual present score for each patient. Each patient's present level of achievement is represented by a vertical line. The solid horizontal lines represent the predicted level.

It will be noted that the lower predictions had a tendency to be too high. The best predictive accuracy was at 30 points. The general tendency has been to be too optimistic, but there has been a strong correlation between prediction and achievement.

In 34 cases (57%) the achievement came within 10 points of the prediction. In 23 cases (38%) the prediction was more than 10 points too high. In 3 cases (5%) the prediction was more than 10 points too low.

**Failures**

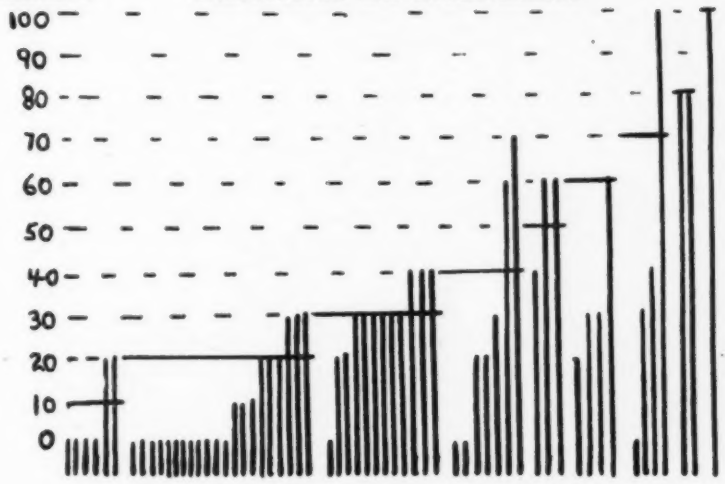
If a patient improves following therapy we are not justified in assuming a cause and effect relationship. If a patient does not improve following therapy we may conclude that therapy was ineffective. Thus, there may be more to learn from our failures than from our successes.

There are about 10 patients who are no better. Seven of these ten were Catatonics, mostly with deterioration. Two were Defectives, one with Psychosis. The other was Manic with Schizoid features. None had even short periods of good adjustment before operation. In only one case had our prediction exceeded 20.

**Conclusions Regarding a Future Group of Patients for Leucotomy**

The fact that 22% of this chronically disturbed group of patients are out of hospital has encouraged us to extend our aims for this group beyond mere reductions in the problems of ward management. We feel that there are many more patients in hospital who may thus be given an opportunity to adjust at home. We feel better equipped to select suitable candidates for operation. A reasonably good prepsychotic adjustment, preservation of personality, some strength of affect, and periods of relatively good adjustment during illness, are good prognostic signs. Deterioration and Mental Deficiency and apathy are poor signs. Length of illness does not appear important.

TABLE F PREDICTIONS AND ACHIEVEMENTS




PRE-OPERATIVE PREDICTIONS ARE REPRESENTED BY HORIZONTAL LINES

ACHIEVED POST-OPERATIVE SCALE RATINGS IN 60 CASES ARE REPRESENTED BY VERTICAL LINES

PRE-OPERATIVE RATING IS 0 IN ALL CASES

(SEE TABLE "A" FOR SCALE RATINGS)

Table F, compares the predicted outcome with the actual result.

**Reflections Concerning the Use of the Point Scale System of Assessing Social Adjustment**

This system, devised at the Toronto Psychiatric hospital, is as useful as anything we have seen for this purpose. It has however, several definite shortcomings. Often the difference between ten and forty is entirely one of whether the family is sufficiently interested in the patient to take him home if he is not a nursing problem. Most features below 50 are measurements of negative quantities.

A more severe handicap of the scale is its lack of consideration of temporal factors. Most patients vary in their behaviour from day to day. A patient may rate 30 except for several days a month, when he may rate 0 due to a disturbed period. Some Manic patients range from 0 to nearly 100. It is difficult to include this temporal factor without making the scale very complex, but without it the scale is often misleading. We have recorded temporal variations thus: 0-30 to indicate the patient who at times adjust at 30, but who is usually at 0. Similarly the 0-30 indicates a good worker who occasionally is a nursing problem,

It is difficult of course to handle these notations in a statistical manner, but they give a better description of the individual patient.

A further difficulty is the need for higher magnification at the lower end of the scale. Many patients after operation showed a distinct improvement, but if they were still nursing problems to some extent they rated 0. Such

improvement could well be recorded by using the range 0 to 10. Thus 5 would indicate that the nursing problem had been reduced by one-half. 30 can be used to indicate work by the patient off his ward, and 25 useful work on his ward.

### Conclusions and Impressions

We feel that an Ontario hospital setting has certain advantages for this type of study. We have a very large group of patients from which to choose. These patients are well known to our staff and any changes following operation are easily and accurately assessed.

Our experience with the Leucotomy program for the chronically disturbed patients has been very gratifying. Assaultiveness, destructiveness and noisiness have been greatly reduced. Much less symptomatic electroshock is required. Most patients are more content and easily managed. Many are living out of hospital who probably would otherwise have required indefinite care. A visit through our disturbed wards shows a striking change since the program was started four years ago. The program is paying for itself financially, apart from the emotional and social profits.

Patients with well preserved personalities and strong affect have shown the best results. Defectives and deteriorated Catatonics have shown the poorest results. There has been less predictability with Catatonic Schizophrenics than with other groups. These findings are in line with those found by other centres working with patients less chronically ill, and may be helpful to other hospitals which are considering setting up a comparable Leucotomy program.

### Note of Appreciation

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### Résumé

L'hôpital Ontarien de Hamilton entreprit en 1952 un programme de lobotomies dans le but d'améliorer les problèmes du personnel hospitalier avec les malades mentaux agités d'une façon chronique. Cet article rapporte les soixante premiers patients de cette étude; ces patients étaient destructeurs, bruyants et agressifs et souvent requéraient de la surveillance au moment des repas, de l'habillage et de la toilette. Ils étaient habituellement confinés dans des cellules et souvent nécessitaient des électro-chocs comme thérapeutique symptomatique. Presque tous étaient malades depuis plus de cinq ans.

L'administration de pentothal et de novocaïne injectée dans le cuir chevelu assura l'anesthésie. Les sections furent effectuées par un leucotome introduit par un trou de trépan au front, à la partie postérieure de la plaque supra-optique. Le leucotome produisit une section transversale de 4 à 5 centimètres dans chaque lobe frontal. La lésion fut ensuite agrandie vers le centre avec une aiguille spéciale. La plupart des patients étaient debout en-dedans d'une journée et furent retournés à leur salle au bout d'une semaine, où une meilleure évaluation des changements pouvait être faite.

Le cas de chaque patient fut présenté en résumé à des réunions du personnel où l'on discutait de l'indication opératoire et des résultats à en attendre. Les

résultats furent évalués après six mois, un an et deux ans. De plus, l'opinion des parents et du personnel de la salle avant et après l'opération, fut très sérieusement considérée. Au moment de la rédaction de ce rapport, des soixante patients, 10 ont été opérés il y a plus de deux ans, 44 depuis plus d'un an, et 6 depuis plus de six mois. Le groupe étudié comprend 41 femmes et 19 hommes.

La tendance à la destruction est disparue chez plus des deux tiers, ce qui signifie une économie considérable de vêtements, de litterie, de matelas, de vaisselle et de vitres. Le tumulte a aussi été réduit des deux tiers. Le besoin de surveillance et de soins d'hygiène personnels n'a été réduit que du tiers seulement. La sociabilité n'a été que très peu améliorée. La plupart des patients ont continué leur vie solitaire et retirée en dépit des encouragements à se mêler aux autres.

Le nombre de patients nécessitant la cellule d'isolement a diminué de moitié. La plupart de ceux qui ont encore besoin d'être isolés, ne le nécessitent que rarement et pour de courtes périodes plutôt que constamment, ce qui a permis au personnel d'intensifier leurs efforts de socialisation et d'occupation thérapeutique. Le nombre de patients qui continuent de recevoir des électrochocs dans un but symptomatique est tombé de plus des deux-tiers, ce qui occasionna une énorme économie de temps.

Il est intéressant de noter que dans la plupart des cas, l'amélioration maxima apparut dans les six mois. Durant la période de deux ans qui suivit, il y eut une importante diminution des sédatifs requis, Vingt-deux pour cent de ces patients ont réussi une adaptation au-dehors de l'hôpital, ce qui fut une agréable surprise pour le personnel.

Les meilleurs résultats furent obtenus chez les maniaques et les paranoïdes, chez qui la personnalité est la mieux préservée et l'affectivité la plus forte. Les résultats chez les schizophrènes catatoniques furent moins constants. Aucune relation significative entre l'âge et les résultats ne fut constatée. Les résultats chez les hommes semblaient être meilleurs que chez les femmes.

Le fait que vingt-deux pour cent de ce groupe chroniquement agité sont actuellement hors de l'hôpital nous a encouragés à élargir les visées de notre étude au-delà de la simple solution des problèmes de salle. Nous sommes d'avis qu'un bien plus grand nombre de patients actuellement hospitalisés devraient profiter de la possibilité de s'adapter à domicile. Une adaptation pré-psychotique raisonnablement bonne, une personnalité suffisamment préservée, une certaine conservation de l'affectivité et des périodes d'adaptation relativement bonnes durant la maladie sont autant de facteurs de bon pronostic. La détérioration, la déficience mentale et l'apathie sont de bien pauvres signes pronostiques.

# LE LARGACTIL CHEZ LES EPILEPTIQUES INTERNES
## (Résultats de trois années d'observation)

M. COULOMBE, M.D. ET J.-Y. GOSSELIN, M.D.

En 1953, alors que le Largactil avait déjà fait ses preuves dans les états d'excitation, nous avons tenté d'abord avec prudence de calmer la colère de certains épileptiques. A cette époque, il était déjà reconnu que ce médicament abaissait le seuil convulsivant, et que par ailleurs il augmentait l'action des barbituriques et des autres dépresseurs.

Au début, il ne fut pas question d'usage prolongé; ce n'est qu'à la longue qu'une certaine technique s'établit, et les premières malades traitées furent celles qui présentaient des paroxysmes dangereux. Il convient, avant d'aborder le vif du sujet de décrire en quoi consiste ce groupe particulier d'épileptiques asilaires. Heureusement la majorité des épileptiques peuvent avoir une vie presque normale mais il existe un groupe formé, il est vrai, d'une variété disparate où se rencontrent des séquelles diverses d'encéphalopathie, avec arriération mentale, chez qui l'épilepsie n'est qu'un des symptômes et des épilepsies soit idiopathiques, soit localisées, dans lesquelles l'E.E.G. montre des projections variables non seulement d'un malade à l'autre mais variables chez un même individu. Le dénominateur commun de ce groupe consiste, pour employer un euphémisme, en des troubles du caractère. Il faudrait une trop longue description pour montrer le polymorphisme de ces conduites qui, traduites sur le plan physio-pathologique, réalisent divers degrés "de destructuration de la conscience". (Henri Ey) Nous les réunissons sous le titre suivant: caractère dit épileptique, remarquable par son entêtement, sa rigidité, son irritabilité, son affectivité souvent visqueuse, fond sur lequel éclate des colères brutales avec ou sans amnésie allant jusqu'à la fureur avec activité clastique et enfin tous les paroxysmes franchement psychotiques tels que les états crépusculaires, confuso-oniriques suivis d'organisations délirantes secondaires de durée variable, parfois chronique. Les anticonvulsivants y sont peu efficaces bien que leur emploi soit nécessaire pour contrôler les convulsions.

Il y a peu à faire contre les paroxysmes que d'endormir ces patients ou de pratiquer parfois quelques électrochocs, quitte à recommencer à la prochaine rechute. Il y a aussi peu à faire contre les troubles caractériels chroniques que de les tolérer ou d'essayer avec un minimum de succès des manœuvres persuasives et d'attendre que patience et longueur de temps fassent leur œuvre, et chacun sait que l'augmentation de la dose des anticomitiaux n'apporte qu'une exagération des troubles du comportement en empêchant l'éclatement d'une crise libératrice.

Nous considérerons l'effet du Largactil sur le comportement, sur la fréquence des crises convulsives et nous signalerons aussi ses effets sur l'état général et sur la formule sanguine. Disons que l'atmosphère de la salle, comme il est maintenant habituel de dire en parlant du largactil, s'est profondément transformée. A l'action médicamenteuse et grâce à cette action sont venus s'ajouter des adjuvants psychologiques tels que les jeux et occupations diverses qui n'étaient possibles autrefois que sur une échelle très restreinte. Les problèmes anciens ont été remplacés par des nécessités complexes qui imposèrent tôt un changement d'attitude de la part du personnel. De plus, il s'agit en général de malades internées depuis plusieurs années; la connaissance de l'évolution parfois plus ou moins cyclique nous évite de surévaluer une amélioration spontanée et passagère.

Toutes les malades ont bénéficié du traitement. Il est maintenant exceptionnel que l'une d'entre elles doive être isolée; les querelles, autrefois si fréquentes, sont plus rares et faciles à régler. Leur état général est meilleur et elles ont à peu près toutes augmenté de poids. Elles se montrent plus fidèles à leur médication et

aussi la survenue d'un état de mal épileptique est exceptionnelle. Quant aux accidents, il ne s'en est produit aucun. Comme incidents, nous pouvons signaler quelques intolérances digestives sans gravité; plusieurs cas de galactorrhée (40%), quelques signes extrapyramidaux. A propos de ces derniers symptômes, nous avons eu trois malades qui ont présenté un syndrome difficile à décrire. Ces malades ont dû garder le lit à cause de troubles de l'équilibre et de l'alternance d'hypertonie et d'hypotonie. De plus, ces trois malades étaient très délirantes et des éléments de suggestibilité et de négativisme compliquaient le tableau. La médication maintenue, le syndrome prit plusieurs jours à s'estomper. Au début de la cure, trois autres malades virent leur état s'aggraver tant au point de vue comportement que de la fréquence des crises convulsives. La formule sanguine, surveillée régulièrement chez les épileptiques, montra un abaissement des globules blancs (de 7000 à 4000), toutefois sans signes cliniques; aucun cas d'agranulocytose ne fut à déplorer. La rapidité d'action du médicament varia de beaucoup. Les états de mal et les autres phases aiguës furent en peu de temps maîtrisés par l'induction du sommeil. Quant aux troubles chroniques, il suffit parfois de deux à trois semaines pour produire une amélioration notable; par contre il fallut attendre de 5 à 7 mois pour voir apparaître un état d'humeur régulièrement calme chez quelques-unes tandis que chez d'autres persistèrent, quoique très amoindries des bouffées d'humeur imprévisibles. Les troubles prémonitoires, de quelques jours ou quelques heures, des crises convulsives disparurent en général ou subsistèrent sous la forme de signes mineurs, humeur taciturne, plaintes, faible rappel des drames d'autrefois.

Nous avons divisé nos 43 malades en 4 tableaux. Le critère qui a déterminé ce classement un peu arbitraire est l'intensité des troubles. Il nous a paru peu utile pour les fins du présent travail de tenter un classement étiologique ou électroencéphalographique.

Le tableau no 1 réunit des malades remarquables par leurs crises psychomotrices violentes (états crépusculaires ou confusionnels fréquents avec libération d'automatisme dangereux) imposant l'isolement quasi habituel chez la plupart.

Toutes ces malades sont maintenant retournées dans la salle; plusieurs peuvent en suivre les activités. Il arrive que quelques-unes amorcent une rechute mais une ou deux injections de Largactil préviennent ce qui autrefois eut demandé des manœuvres compliquées et un isolement de plusieurs jours. Certaines d'entre elles ont appris à nous avertir à temps et viennent nous informer qu'elles "se sentent nerveuses et désirent des piqûres pour calmer leurs nerfs et mieux dormir".

De plus, le caractère intercalaire aux crises reste remarquablement stable; elles se montrent gaies et souriantes. A l'évocation de leur irritabilité antérieure, elles répondent souvent: "Je ne me contrôlais pas, un rien m'énervait, à présent je prends sur moi ou cela ne me fait plus fâcher".

Une restriction cependant s'impose au sujet des résultats de ce premier groupe. Il s'agissait, comme il a été dit, de malades très difficiles, souvent isolées, sujettes à des états crépusculaires ou de confusion: elles étaient donc souvent exposées à refuser leurs médicaments ou à les cacher. En conséquence, il fallait employer la méthode intramusculaire et lorsque le calme s'établissait, elles acceptaient alors le Largactil et les anticonvulsivants qu'elles prennent régulièrement depuis. Il est donc évident qu'on ne saurait négliger qu'à la suite du Largactil, la fidélité au Dilantin et au Gardénal contribue à accentuer le degré d'amélioration. Par ailleurs, sans Largactil, il eut été physiquement impossible d'obtenir ce calme et cette coopération. De toute façon, il nous semble qu'un traitement I.M. au début, donne des résultats plus rapides et plus profonds. Voici un résumé de quelques cas.

TABLEAU I: MALADES SOUVENT VIOLENTES (CAS DE CELLULE)

| Patientes | Durée du traitement en mois | Changement de Comportement | | | Fréquence des crises par mois | |
|---|---|---|---|---|---|---|
| | | très améliorée | améliorée | Peu améliorée | Avant | Pendant |
| 1 — M. J. D. | 7 | | X | | 1.0 | 0.7 |
| 2 — S. D. | 39 | | X | | (b) | – |
| 3 — A. D. | 17 | X | | | 2.9 | 0.5 |
| 4 — M. M. D. | 7 | | X | | 0.7 | 2.1 |
| 5 — T. C. | 9 | | X | | 0.7 | 0.3 |
| 6 — H. G. | 13 | X | | | 2.3 | 1.3 |
| 7 — G. L. | 15 | | X | | 0.4 | 0.25 |
| 8 — L. M. | 14 | X | | | 3.4 | 1.5 |
| 9 — M. M. | 17 | | X | | 2.0 | 0.4 |
| 10 — R. P. | 14 | | X | | 5.6 | 0.3 |
| 11 — L. P. | 17 | | X | | (a) | – |
| 12 — G. B. | 39 | | X | | (b) | – |
| 13 — A. J. | 3 | X | | | (c) | – |
| 14 — D. G. | 3 | | X | | (c) | – |

(a) Aucune avant ni après.
(b) Fréquence mal connue avant.
(c) Trop tôt, crises non augmentées à date.

*Cas no 1 — M.J.D. 26 ans*, hospitalisée depuis novembre 1951. Epilepsie — foyer épileptique temporal gauche — exploration neurochirurgicale en 1953. Depuis au minimum deux ans, elle vit en cellule à cause d'impulsions, vociférations, périodes fréquentes de confusion, essaie de se frapper sur les murs. Médications à cette époque: Dilantin (1½ gr. b.i.d.) et Gardénal (h.s.). En juin 1956, après une série de 22 injections I.M. de Largactil, elle s'adoucit et accepte 100 mg. t.i.d. per os. Depuis déjà plusieurs semaines, elle passe ses journées dans la salle et elle n'a plus d'impulsion. Son état mental s'améliore progressivement, elle réussit à écrire à ses parents mais il persiste un affaiblissement intellectuel qu'autrefois il était impossible d'évaluer. Les crises convulsives, quoique la période d'observation ne soit pas suffisamment longue, semblent devoir diminuer. En 32 mois, l'on compte 43 crises tandis qu'après le début du Largactil, l'on compte 5 crises en 7 mois; soit 1.0 crise par mois avant et 0.7 crise après.

*Cas no 3 — A.D. 34 ans*, admise en 1938. Débilité mentale épilepsie (Grand mal). Première crise convulsive à six semaines. Depuis l'âge de 16 ans, gros troubles caractériels. Elle était impulsive, sournoise, jalouse, criait parfois durant des heures et toutes les semaines elle devait passer à 3 jours en cellule. Même lorsqu'elle était dans la salle, une surveillance stricte s'imposait à cause de la soudaineté de ses colères. Elle recevait alors Dilantin (1½ gr. t.i.d.) et Gardénal (1½ gr. b.i.d.). En novembre 1953, nous essayons le Largactil à raison de 50 mg.

t.i.d. I.M. Nous devons bientôt cesser car elle se montre plus agressive et ses crises convulsives augmentent. Même tentative inutile en 1954. En juin 1955, le Largactil est repris, mais cette fois le Gardénal à dose plus importante lui est associé – 8 à 10 grs par jour pendant une dizaine de jours. Les crises convulsives n'augmentent pas mais ce n'est qu'après 7 mois qu'une amélioration nette se produit. Son comportement est régulièrement stable, elle aide, se montre de bonne humeur, son poids augmente et en même temps est disparue l'acné pustuleuse qui, ajoutée à sa maigreur lui donnait un air si pitoyable malgré sa malice et ses sournoiseries. En 57 mois, elle avait fait 168 crises, dans les 17 mois qui suivirent la troisième tentative de traitement, elle n'en a fait que 8 et *aucune depuis un an*, soit 2.9 crises avant et 0.47 crise après. L'électro-encéphalogramme qui n'avait jamais pu être pratiqué montre un tracé normal en date du 5-10-56. Sa débilité mentale l'empêchera probablement de quitter les murs d'une institution.

*Cas no 6 – H.G. 27 ans*, admise en 1946. Arriération mentale profonde, épilepsie. E.E.G. le 23-2-55 tracé présentant des anomalies généralisées d'encéphalopathie diffuse. Médication antérieure: Dilantin (1½ gr. b.i.d.) et Gardénal (1½ gr. b.i.d.). Malade d'une grande maigreur. Elle présente de plus une hypertrichose marquée. Quelques jours avant ses 2 ou 3 crises convulsives mensuelles, elle devient très agitée, brise tout. De plus, aux 2 mois, elle présente une période de négativisme de quinze jours avec refus d'aliments et atteinte sérieuse de l'état général. Elle s'apaise après trois semaines de traitements au Largactil, commencé le 10-12-55 à raison de 50 mg. t.i.d. per os. Elle n'a plus jamais représenté les troubles prémonitoires à ses crises convulsives. Elle supporte bien la contrariété, vient chercher d'elle même ses médicaments, suit le mouvement de la salle. L'état physique est floride et surtout elle s'alimente régulièrement. Elle conserve quoique lucide une grande pauvreté idéique, avec bradypsychie et une tendance à la persévération verbale, tous phénomènes liés à son affaiblissement intellectuel et non pas à un syndrome extrapyramidal car elle n'en offre pas les troubles moteurs. Elle s'occupe à colorier avec soin des cahiers destinés aux enfants et en est très fière. Durant les 57 mois précédant sa cure, elle avait 131 crises convulsives, soit 2.3 crises par mois. Depuis, l'on compte 18 crises en 13 mois, soit une moyenne de 1.3 crise. La médication antérieure de Dilantin et de Gardénal demeure la même et elle prend encore 100 mg de Largactil t.i.d.

*Cas no 7 – G.L. 33 ans*, admise en 1949. Epilepsie, grand mal – arriération mentale. Dilantin 1½ gr. t.i.d. et Gardénal b.i.d. Depuis son admission, à tous les quatre ou cinq jours, obligation du gilet, agressivité dégénérant en fureur épileptique, monte dans les grillages, automutilation et entre temps chicanière. Traitée au Largactil depuis le 6 octobre 1955. Depuis mars 1956, ses accès ont beaucoup moins d'éclat et sont plus espacés. Une série d'injections la maîtrise rapidement. Meilleure humeur dans les périodes intercalaires. E.E.G. tracé montrant des anomalies d'allure épileptique prédominant à la région temporale droite. En 56 mois elle avait fait 23 crises et après traitements, 4 crises en 16 mois; soit 0.4 crise par mois avant et 0.25 crise par mois après.

*Cas no 9 – M.M. 30 ans.* admise en 1953 après plusieurs hospitalisations en d'autres milieux. Epilepsie idiopathique, caractérielle avec explosion coléreuse, violente, clastique survenant à tout moment et à la moindre contrariété. Célèbre par ses réactions hystériformes. L'isolement est nécessaire souvent. Même calme, la vie commune n'est guère possible car elle conserve un état d'entêtement invincible. Bien qu'orientée et apparemment lucide, elle garde d'une façon chronique une conscience très rétrécie. En août 1955, la cure est commencée en injections. Par la suite, les doses "per os" varièrent de 100 à 300 mg. Quatre mois après le

TABLEAU II: CARACTÉRIELLES — PAROXYSMES MOINS FRÉQUENTS QUE TABLEAU NO I

| Patientes | Durée du traitement en mois | Changement de Comportement | | | Fréquence des crises par mois | |
|---|---|---|---|---|---|---|
| | | Très améliorée | améliorée | Peu améliorée | Avent | Pendant |
| 1 — M. B. B. | 14 | X | | | 0.8 | 0.8 |
| 2 — M. A. C. | 7 | | X | | 0.0 | 0.0 |
| 3 — P. D. | 7 | | | X | 0.6 | 1.1 |
| 4 — M. F. | 12 | X | | | 1.6 | 0.0 |
| 5 — B. H. | 16 | | X | | 1.9 | 1.8 |
| 6 — M. A. H. | 15 | | X | | (a) | – |
| 7 — M. B. L. | 13 | | | X | 2.5 | 0.1 |
| 8 — J. P. | 19 | X | | | 1.0 | 0.0 |
| 9 — A. R. | 11 | X | | | 3.4 | 1.4 |
| 10 — C. T. | 5 | | X | | (a) | – |
| 11 — F. V. | 7 | | | X | (a) | – |
| 12 — J. O. | 5 | X | | | 4.9 | 1.0 |
| 13 — N. M. | 5 | | X | | 0.0 | 0.0 |

(a) Fréquences non connues avec précision avant traitement.

début, elle devient plus calme, les colères s'atténuent et s'espacent. A venir jusqu'en décembre 1956, elle fut calme, aimable et travaillait. Malheureusement, la période des Fêtes, apporta une contrariété. Elle s'attendait à un congé qui ne fut pas possible. Et l'on assista à une rechute qui avec l'augmentation du Largactil se corrigea peu à peu. De plus les doses avaient dû être souvent diminuées à cause des troubles digestifs. Nous considérons cette malade comme améliorée quoique nous ayions été tentés de la classer comme très améliorée lorsque nous nous rappelons son comportement antérieur avec celui des douze derniers mois. En 22 mois, elle avait présenté 44 crises soit une moyenne de 2 crises par mois; par la suite en 17 mois l'on compte 7 crises, soit 0.4 crise par mois.

Dans un second tableau, il s'agit de malades dont les troubles prémonitoires sont moins marqués que chez les précédentes. Celles-ci présentent habituellement, dans les périodes intercalaires, des troubles du caractère: entêtement, irritabilité, jalousie, obséquiosité, tendance aux revendications et aux critiques sans fin.

Médication antérieure non modifiée.

*Cas no 1 – M.B.B. 38 ans*, admise en 1947 pour épilepsie idiopathique, grand mal et troubles du caractère. On notait environ une crise par mois, précédée pendant deux jour environ de colère et d'agressivité. Le comportement était relativement tolérable en dehors de ces épisodes.

Le 9 novembre 1955, elle reçoit Largactil 50 mgms t.i.d. Deux mois plus tard, les troubles prémonitoires disparaissent; les crises convulsives gardent le même rythme, (légère augmentation de 0.77 à 0.80). Cette patiente travaille régulièrement depuis lors et se montre beaucoup plus sociable.

E.E.G. le 23-1-57 – tracé amélioré, mais nettement indicatif d'épilepsie idiopathique.

*Cas no 4–M.F.*, est a mise en janvier 1955, à 17 ans, pour épilepsie: grand mal, avec troubles de l'humeur et du caractère. L'E.E.G. d'alors montrait "des anomalies continues d'encéphalopathie diffuse".

Depuis l'enfance, elle se montrait désobéissante, entêtée, chicanière, mais le plus souvent insouciante, capricieuse et instable. Ses tendances mythomaniaques exigeaient un retrait absolu de la société. Le Dilantin soit 1½ gr. t.i.d. et le Gardénal 1½ gr. h.s. avaient diminué la fréquence des crises mais une désespérante immaturité émotionnelle persistait.

En janvier 1956, le Largactil est commencé à raison de 25 mgms. t.i.d. et après à 50 t.i.d. Nous assistons à une amélioration progressive du tableau clinique, les crises convulsives (aucune en 12 mois) semblent contrôlées, et les troubles du caractère heureusement modifiés.

Son activité devient constante, soutenue, son humeur stable lui permet une plus grande souplesse d'adaptation et surtout elle respecte davantage la vérité qu'autrefois elle semblait prendre plaisir à déformer au gré de son imagination sans frein.

Deux E.E.G. de contrôle réalisés pendant le traitement au Largactil se révèlent normaux. En raison du jeune âge et de la nature des signes électroencéphalographiques, on peut présumer qu'une amélioration spontanée eut pu se produire avec le temps ou avec les anticonvulsivants seuls.

*Cas no 8 – J.P.* est admise à 28 ans en 1947 pour épilepsie et débilité mentale avec troubles du caractère. Elle prenait Dilantin 1½ gr. b.i.d. et Gardénal 1½ gr.h.s. On notait une crise convulsive par mois. Cependant la malade était irritable, jalouse, menteuse, souvent insupportable pour les compagnes, elle devait être placée en réclusion quelques jours par mois. Par ailleurs, elle était très active.

En juin 1955, elle reçoit 150 mgms. i.d. puis 200 mgms. i.d. en décembre suivant. Depuis la fin d'octobre 1955, elle n'a été isolée qu'une fois. On note parfois des troubles du caractère quelques jours avant ses menstruations mais on l'entend rarement disputer, elle conserve une exubérance très tolérable et elle demeure très active. Aucune crise convulsive n'a été notée depuis qu'elle reçoit le Largactil.

*Cas no 12 – J.O.* est hospitalisée en 1948 pour épilepsie et arriération mentale avec troubles de l'humeur et du caractère à tel point que l'isolement devient souvent nécessaire. Le Dilantin 1½ gr. t.i.d. et le Gardénal 1½ gr. H.S. ne semblent apporter d'amélioration notable aux crises et au comportement.

En juillet 1950, on donne Pacatal, ce qui semble avoir diminué les crises mais a peu agi sur le caractère. Au début de septembre 1956, la malade prend Largactil; les crises sont fortement diminuées dès les premières semaines et depuis le 13 novembre, aucune ne s'est produite.

Tout en demeurant une arriérée mentale, la malade est calme, plus sociable, elle s'occupe, elle supporte mieux les contrariétés et peut poursuivre une existence plus agréable.

Le tableau no 3 réunit des malades qui en plus ou à cause de leur épilepsie présentent des états psychotiques chroniques.

1 – Schizophrénie – épilepsie – grand mal.
2 – Schizophrénie – épilepsie acinétique.
3 – Délire hallucinatoire et d'influence à thème érotique et épilepsie.
4 – Epilepsie – confusion et délire oniroïde tenace.

TABLEAU III: PSYCHOSES DIVERSES: CHRONIQUES OU PROLONGÉES AVEC ÉPILEPSIE

| Patientes | Durée du traitement en mois | Changement du Comportement | | | Fréquence des crises par mois | |
|---|---|---|---|---|---|---|
| | | Très améliorée | améliorée | Peu améliorée | Avant | Pendant |
| 1 — L. A. | 16 | | X | | 1.8 | 1.5 |
| 2 — A. A. | 15 | | X | | 1.1 | 1.1 |
| 3 — M. B. | 8 | | X | | (a) | – |
| 4 — M. B. | 8 | X | | | 5.5 | 1.8 |
| 5 — J. D. | 8 | | X | | (a) | – |
| 6 — M. P. G. | 5 | | X | | 4.4 | 4.4 |
| 7 — J. P. | 8 | | X | | (a) | – |
| 8 — F. P. | 16 | | X | | (a) | – |

(a) Rythme non connu avant.

5 – Epilepsie – accès confuso-stuporeux.
6 – Epilepsie myoclonique et délire chronique incohérent.
7 – Epilepsie – confusion – état oniroïde avec délire mystique.
8 – Epilepsie – délire d'interprétation à thème de persécution, agressivité marquée.

Signalons qu'avant traitement, la malade no 1 – L.A. présentait un tracé E.E.G. normal et la malade no 2 – A.A. un tracé E.E.G. contenant des irrégularités mineures insuffisantes pour prouver l'épilepsie. Après quelques mois de Largactil, les deux tracés révélaient une épilepsie d'allure idiopathique.

TABLEAU IV: IMBÉCILES ÉPILEPTIQUES

| Patientes | Durée du traitement en mois | Changement du Comportement | | | Fréquence des crises par mois | |
|---|---|---|---|---|---|---|
| | | Très améliorée | améliorée | Peu améliorée | Avant | Pendant |
| 1 — A. B. | 14 | X | | | 0.5 | 1.1 |
| 2 — M. L. | 7 | | | X | 1.0 | 3.0 |
| 3 — J. M. | 22 | | X | | 3.6 | 0.4 |
| 4 — P. R. | 21 | X | | | (a) | – |
| 5 — T. R. | 8 | | X | | 1.1 | 0.6 |
| 6 — C. R. | 16 | | X | | (a) | – |
| 7 — R. S. | 8 | | X | | 6.5 | 3.0 |
| 8 — R. M. | 20 | | X | | 0.5 | 0.15 |

(a) Rythme mal connu avant.

TABLEAU V

| Nombre de patientes | Durée moyenne du traitement | Changement du comportement | | | Fréquence des crises | | |
|---|---|---|---|---|---|---|---|
| | | | | | Crises | mois | patientes |
| | | T.A. | A. | P.A. | Avant | | Pendant |
| 43 | 12.8 mois | 12 | 27 | 4 | (a) 2.13 | | (a) 1.05 |

(a) Calculé sur un total de 29 patientes dont la fréquence des crises était bien connue avant le traitement.

Par contre, un E.E.G. de contrôle, le 20 novembre 1956, révèle chez la malade no 6 – M.P.G. une amélioration du tracé qui contient encore des signes d'encéphalopathie, mais pas de décharge myoclonique.

Enfin dans ce dernier groupe, il s'agit de malades très arriérées. Le Largactil a eu pour effet de les rendre souriantes et plus dociles. Elles semblent atteindre actuellement l'amélioration limite que leur permet leur intelligence.

Une période d'observation de 3 ans (de 3 mois à 39 mois) nous permet de conclure à l'efficacité indiscutable du Largactil sur les troubles du comportement des épileptiques asilaires.

De plus l'association Largactil et anticomitiaux apporte une diminution notable de la fréquence des crises convulsives.

Au sujet de ce dernier point, l'on relève dans la littérature une divergence d'opinion attribuable à notre avis soit à une période d'observation trop courte, soit à une dose insuffisante d'anticonvulsivants.

N.B.—Les E.E.G. ont été interprétés par le Dr Martin. Nous tenons à remercier pour leur précieuse collaboration Mère Marie des Chérubins ainsi que garde Thérèse Baillargeon.

**Summary**

Forty-three institutionalized female patients were treated with a combination of Largactil and anti-epileptic drugs over periods ranging from three to 39 months (mean: 12.8 months). There have been no accidents. As to incidents, there have been a few cases of mild gastro-intestinal intolerance, a number of cases of galactorrhea, and a few extrapyramidal symptoms. Blood tests, which were made regularly, showed a lowering of the BC (from 7000 to 4000), but without any clinical signs.

Treatment was effective in every patient. In chronic conditions, two or three weeks were sometimes sufficient to produce notable improvement of mood; on the other hand, some of the patients began to show a consistently calm mood only after five to seven months. From a total of 43 patients, 12 were markedly improved; 27 were improved and 4 were slightly improved.

It can be concluded that Largactil is undoubtedly effective in the behavioral disturbances of institutionalized epileptics. Moreover, the combination of Largactil with anti-epileptic drugs produces a notable reduction in the incidence of convulsive seizures.

# Proceedings of the 8th Annual Meeting

## Canadian Psychiatric Association

The President, Dr. E. Hobbs, called the meeting to order at 2.15 p.m., June 20th, 1958, in Halifax. Approximately fifty members were present.

### President's Report

The President spoke briefly to the members of the Canadian Psychiatric Association at the Annual Meeting in Halifax, Nova Scotia in June of this year. He emphasized that we have every reason to be pleased with the progress of our Association. The membership continues to expand and now is quite representative of the psychiatrists across the country. Our Journal, too, is a matter of considerable pride. It is developed into an extremely useful organ, covering many important scientific aspects of psychiatry and serving an extremely vital function as the voice of psychiatry in Canada. No other way could communication be possible in a country as widespread as ours.

In addition, he emphasized the progress being made in the organization of graduate training in psychiatry. He pointed out that psychiatric education on a graduate level in an organized fashion was a relatively recent development, preceded in time by many other specialty areas. Over the years progress has been made and certain disagreements have arisen concerning the best form that training should take. He emphasized that arguments and difficulties encountered in psychiatric training were a simple repetition of many of the issues raised in other areas of Medicine, when Medicine made the transition from an apprenticeship to an academic type of training.

The President also extended congratulations to our two most active and hard-working members, namely, the Secretary and the Editor of the Journal. Without willing participation by Dr. Roberts and Dr. Chalke, the organization could not possibly have grown and succeeded as it has. However, no one or two persons are responsible entirely for the success of an organization.

Our committees have been many and well directed. Numerous areas of vital importance to psychiatry in general have been handled at length by many members representing many areas of interest. We can truly feel that the Canadian Psychiatric Association is now a vital force in the field of Psychiatry in Canada.

* * * *

### Report of Secretary

It seems appropriate at this time to briefly mention a few of the salient points in the history of our Association. On May 25, 1949, some 71 members of our specialty held a meeting which led to the formation of our Association. Further meetings were held on May 3, 1950 and in June 1950 which led to the approval of a draft constitution. The Inaugural Meeting was held on June 20, 1951 in Montreal. There were 143 Charter Members of the Association. Dr. R. O. Jones was the first President of our Association and it seems fitting to pay tribute to his efforts at this first meeting of our Association in Halifax. Dr. R. O. Jones has played a very active part in our early history and has made outstanding contributions to the development of psychiatry in this country. The success of his efforts and of all those who had the foresight to form this Association is best demonstrated by our growth and activities. Our membership has grown tremendously — from 143 in 1951, to 170 in 1952, to 185 in 1953, to 350 in 1955, to 437 in 1956, to 462 in 1957 and 493 in 1958. The importance and strength of our Association has been recognized by other bodies — we are advisory to C.M.A. in mental health matters, we now nominate the Committee on Psychiatry of the R.C.P. and S. and so on. We have many very active committees and through the combined efforts of all of our members we are making our opinions known and appreciated. Through the efforts of Dr. Boothroyd and Dr. Chalke, we have progressed through a Bulletin to a creditable Professional Journal which is rapidly gaining worldwide recognition. If we can continue to dispassionately discuss our problems, develop solid association points of view, and express and support these with unity, we can gain increased influence which will be reflected in better services for our patients and for Canadians generally.

During the year your Directors have held three meetings – a brief one in Edmonton to appoint committees, a meeting in Toronto to review committee work, and a full day meeting yesterday. The Committees have been very active as will be indicated by the reports to be presented this afternoon.

I would like once again to express my appreciation for the opportunity I have been given to be of service to our profession. Being your Secretary is a rewarding and satisfying

job. I do not know of any member who has failed to assist and assume an active role when called upon to do so. Our committee chairmen have been most cooperative and have laboured arduously in our interest. The other officers, especially Reg Hamilton and Rhodes Chalke, have been very tolerant and have made my work easier than it would ordinarily be. Our President, Dr. Hobbs, has always had time from his busy round of duties to attend to the affairs of our Association and I want to express to him my sincere thanks. I have now worked with a number of presidents – Dr. Stogdill, Dr. MacLean, Dr. Pottle, and Dr. Hobbs – no association could have had more devoted and interested Presidents! Thank you.

The Secretary presented this report and moved its adoption. Seconded by Dr. Stokes. Adopted.

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**Treasurer's Report**

Attached hereto is the report of receipts and disbursements for the year 1957. For the year, our expenditures exceeded our receipts by $473.60. Two major items of expenditure are worthy of comment: payment of the Journal deficit of $237.21 for the year 1956 was approved at the last Annual Meeting and should be a non-recurring item; secondly; $400.00 was paid towards the expenses of our delegate to the International Congress of Psychiatry which occurs only every four to seven years. During the year the Directors authorized an advance towards the cost of the C.M.H.I. and this amount has been fully repaid since the financial statement was completed.

FINANCIAL STATEMENT

| Assets | 1956 | 1957 | Decrease — Increase + |
|---|---|---|---|
| Bank Balance as at December 31 | 3,104.75 | 2,029.30 | —1,075.45 |
| Dues from C.M.H.I. | | 601.85 | + 601.85 |
| Imprest Fund — Secretary | 100.00 | 100.00 | |
| | $3,204.75 | $2,731.15 | — 473.60 |

Balance Sheet

| | | |
|---|---|---|
| Balance at 31 December 1956 | | 3,204.75 |
| Receipts for 1957 | | 1,773.50 |
| | | $4,978.25 |
| Disbursements for 1957 | | |
| Journal | 1,035.21 | |
| | | (237.21 for deficit in 1956; 698.00 for current members) |
| Delegate to International Congress of Psychiatry | 401.00 | |
| Annual Meeting Expenses | 323.45 | |
| Committee Expenses | 5.40 | |
| Dues International Congress of Psychiatry | 5.50 | |
| Secretarial Assistance | 235.00 | |
| Printing, Stationery and Stamps | 189.61 | |
| Membership Refunds | 7.15 | |
| Bank Charges | 44.78 | |
| Total | 2,247.10 | |
| Balance as at 31 Dec. 1957 | 2,731.15 | |
| | $4,978.25 | |
| Excess of Disbursements over Receipts | $ 473.60 | |

Budget 1958

| | |
|---|---|
| Petty Cash — Sect. | 100.00 |
| Clerical and Secretarial Work | 250.00 |
| Treasurer's Expenses | 50.00 |
| Printing and Stationery | 75.00 |
| C.P.A. Journal | 1,000.00 |
| Annual Meeting Expenses | 325.00 |
| Total Expenses | $1,800.00 |
| Estimated Income | 1,750.00 |
| Deficit | $ 50.00 |

The estimated budget does not include any payment of expenses to members attending meetings, etc. It might be noted that expenses are climbing steadily while income has not increased to any extent, last year's deficit was approx. $475.00 (not counting loan to C.M.H.I.) and if this trend continues, it will be necessary to increase the annual dues.

The Board of Directors having considered this report and that of the Editor of the Journal, have recommended the setting up of an Ad Hoc Committee on Budget to study the general finances of the Association and the Journal including the matter of membership fees.

The Secretary presented this report on behalf of Dr. Hamilton and moved its adoption. Seconded by Dr. Stokes. Carried.

Dr. Stokes moved, seconded by Dr. Lawson that "The Meeting record an appreciation of the work done by Dr. Hamilton and his continued endeavours on behalf of the Association". Passed unanimously.

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## Journal Management Committee

1. The Journal has continued publication quarterly in the same format as the previous year.

2. Over the past twelve months we have received approximately 61 manuscripts, and 17 papers have been published.

3. We have now over 125 non-membership subscriptions and approximately twelve free and exchange subscriptions.

4. It is the present practice of the Journal to publish classified advertisements concerning positions vacant and appointments sought, the rate being approximately $15.00 for one-fifth of a page. Less use has been made of "Employment Vacancies" than we had hoped.

5. *Editorial Policy*

The Journal is now nearing the end of the third year of publication and it is time to determine whether any changes in the editorial policy for the future are to be made.

*The Editorial Board* originally appointed to launch the Journal has been faithful in their commitments and assistance.

The Editor is conscious of a need to improve the literary style and to overcome the somewhat pedestrian tone of the Journal. It is, therefore, recommended that in January 1959, when the term of the present Board expires, a new, somewhat smaller and, hopefully, more critically participating Board be appointed, composed of the following members:

Dr. J. B. Boulanger — Montreal
Dr. Heinz Lehmann — Verdun
Dr. E. Hobbs — London
Dr. D. Lewis — Toronto
Dr. Humphrey Osmond — Weyburn
Editor — Dr. F. Rhodes Chalke
Assistant Editor — Dr. Marcel Berthiaume

Our French speaking colleagues have put forward the suggestion that a definite amount of space be allocated to the regular publication of French papers and this would be under the Editorship of the Assistant Editor, Dr. Berthiaume. It is proposed to introduce this change on a trial basis in 1959.

6. *The Financial Statement* of the operation of the Journal for the year 1957 is attached. It is to be noted that though we increased the number of pages of text by 15% over the previous year we were able to stay within the anticipated budget.

The system of reimbursing the Editorial Assistant, as approved at the last meeting, has been put into effect.

7. *Budget 1959*

It is planned to continue publication of the Journal as in 1958. This should be possible at the current level of revenue *if publication costs do not rise*. However, from the long term point of view, the membership at large must give consideration *now* to the following facts.

During the past five years the Bulletin, and later the Journal, have been operated from the Editor's personal office. Changed circumstances three years ago have made it unnecessary for the Editor to retain a private office for his own use, and ad hoc arrangements have been made since.

For financial reasons plans will have to be made now for the setting of an independent Journal office by the Association by July 1959.

The estimated rental of one small office would be at least $300 per year, plus the provision of adequate office furniture and equipment—approximately $1,000 which could be amortized over a period of ten years.

A more practical alternative might be the procurement of a Secretarial H.Q. for the Association in Ottawa which could then include the Editorial offices but this would, of course, entail a higher expenditure.

The amount of secretarial and stenographic assistance that would be required would depend on the overall duties of such a headquarters. For the Journal alone it would cost approximately $850 per year.

Any increase in Advertising and Subscription revenue should be devoted to enlarging the Journal. Therefore the additional revenue required to meet the expenses noted above will necessitate an increase in the "per capita" grant to the Journal from the Association.

It is requested that the present $2 rate per member be doubled.

8. We propose to continue to have the Journal printed at the Runge Press Ltd., Ottawa.

9. We recommend the appointment of George Welch & Co. to be auditors of the accounts for the present year.

10. We would like to express our thanks to the Editorial Assistant, V. E. Appleton, for her continued interest in the development of the Journal.

The Editor, personally, would like to draw the attention of the members to the valuable contribution of Dr. Marcel Berthiaume in providing translation services.

## STATEMENT OF REVENUE AND EXPENDITURE

For year ended December 31, 1957

| | | | |
|---|---|---|---|
| *Revenue* | | | |
| Subscriptions—members | | 798.00 | |
| —others | | 472.00 | |
| | | | 1,270.00 |
| Advertising | | 3,371.30 | |
| less Discounts allowed | | 305.74 | |
| | | | 3,065.56 |
| Sale of reprints | | | 772.55 |
| | | | 5,108.11 |
| *Expenditure* | | | |
| Salary | | 600.00 | |
| Journal—printing | 3,121.40 | | |
| —reprints | 549.76 | | |
| —mailing | 104.65 | | |
| | | 3,775.81 | |
| Office supplies and stationery | | 197.43 | |
| Postage and miscellaneous expense | | 173.46 | |
| Bank charges | | 64.07 | |
| | | | 4,810.77 |
| Excess of Revenue over Expenditure for year | | | 297.34 |

NOTE: Revenue item "Subscriptions — other" includes payments received in 1957 for 1958 issues of the Journal.

Submitted with our report dated June 5, 1958.

Geo. A. Welch & Company
Chartered Accountants

Dr. Chalke, Editor of the Journal, presented this report. He reported that the Directors had concurred with all sections except number 7 which was to be referred to a special committee. He moved adoption of his report with section 7 for information only. Seconded by Dr. Stokes. Carried.

Moved by Dr. Stokes "That this meeting record our deep appreciation of the work done by Dr. Chalke and Dr. Berthiaume". Seconded by Dr. Jones. Carried unanimously.

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### Report of the President as Official Delegate from the Canadian Psychiatric Association to the International Congress in Psychiatry, Zurich, Switzerland, September 1957

The President reported briefly at the Annual Meeting concerning his experience as official delegate from the Canadian Psychiatric Association to the International Congress in Zurich. This meeting was an outstanding success, occupying the whole of one week and with the central theme of discussion that of The Group of Schizophrenias.

The business session was particularly interesting and offered an opportunity for a firsthand contact with outstanding psychiatrists in many countries in the world. No major decisions were arrived at on this occasion. However, the question of the next meeting of the International Congress was discussed at length. It was recommended that the time between con-

gresses be extended from the custom of four years in the past to seven years in the future. This means that the next congress will be in 1964. The location of the next congress, too, was the subject of considerable discussion. Canada was suggested as a possible place of meeting but this suggestion was not received with outstanding enthusiasm by the European delegates. Most of them felt that they were unable to meet the financial commitments involved. Moreover, Canada, being a member of the hard currency media countries presented additional difficulties. No firm decision was reached. It is left with a standing committee to decide on the place of meeting. The possibilities are that it be South America, which will present a difficulty in distance, but not the difficulties of convertibility of currency.

The scientific discussions were extremely numerous and no one delegate could attend more than a fraction of these. A number of general impressions came out of these discussions, however. The first was that everyone seemed convinced that the concept of schizophrenia has been broadened over the years until it no longer is meaningful. One suggestion coming out of the meeting was that we should reserve the term Schizophrenia for the hard core type of patients, very similar to the original description. In this way, it would be meaningful for different areas in the world. We might designate the borderlline type of conditions as schizophrenic-like disorders. In this way, one could compare various investigations from area to area. This is impossible at the present time with our usage of the term.

The current metabolic researches carried out on schizophrenia also received considerable attention. There is good evidence of increasing scientific maturity in the quality of reports. For example, no longer are many of the metabolic abnormalities reported for schizophrenias accepted without consideration of many other variables which might well influence the results. This has not been the custom in the past.

In summary, one can state that this was a worthwhile meeting, served its function well, and our hosts in Switzerland were magnificent.

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**Report of Delegate to General Council of Canadian Medical Association**

The undersigned was present at all of the meetings of Council on June 16 and 17 past.

While little specific attention was given to psychiatric matters, it was very satisfying to note the attitude and interest which was apparent in the few sessions when such matters were discussed. The Council meetings also provided an opportunity for informal discussion with a number of individuals which were helpful and hopefully will further strengthen our relationships with C.M.A.

The following specific items appear worthy of comment:

1. The Report of the Committee on Hospital Service and Accreditation makes reference to mental hospitals as follows:

"In 1957 the Joint Commission began surveying mental hospitals and several mental hospitals in Canada were allocated for survey during 1958. The Canadian Commission has made representation to the Joint Commission to have Canadian mental hospitals deleted from the lists for survey in 1958 in order that the Canadian Commission on Hospital Accreditation could meet with the Canadian Psychiatric Association and work out a suitable program for survey of Canadian Mental institutions."

This recommendation was accepted. Dr. McNeel's report will indicate further developments in this respect.

2. The Report of the Committee on Economics states: "The General Council at its last meeting approved a recommendation of the Committee on Economics to the Executive Committee:

'That section 3 of the reference on relative values for medical services be studied by a central committee to be appointed by the Executive Committee; that this committee might under the aegis of a Division of the C.M.A. willing to undertake the study; that terms of reference be established for a relative value study; that personnel be provided to conduct the study and that finances be made available for its support.'"

It is recommended that a suitable letter be forwarded to C.M.A. to ensure that the relative values of psychiatric services are adequately considered.

3. The Constitution and By-Laws of C.M.A. have been under continuous review for several years. Last year a chapter dealing with sections was returned to this Committee for further study. A new chapter was approved this year dealing with sections and it is felt that the following quotes are relevant to our Association:

" . . . As a general principle, an application for the formation of a section shall not be granted if an affiliated body already exists in the same field and in any case the Executive Committee shall not grant approval until the existing affiliated body, if any has been notified of

the proposed new section and is provided with an opportunity to express its opinion on the function of such a section".

" . . . The activities of sections shall be confined to such areas as do not conflict with the responsibilities of the Divisions or of the affiliated national medical societies."

Thus it appears that conflict of interest between sections and affiliated national medical societies will not and cannot develop.

All of which is respectfully submitted.

C. A. ROBERTS, M.D.

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## Report of Delegate to National Scientific Planning Council of Canadian Mental Health Association

The Tenth Annual Meeting of the National Scientific Planning Council of the C.M.H.A. was held in the Board Room of the Canadian Medical Association, 150 St. George Street, Toronto on February 28 and March 1, 1958.

Dr. B. H. McNeel, Chairman, presided with 36 members and consultants taking part in the two day meeting.

Topics discussed during the meeting were as follows:

1. Report of Committee on Public Education in Mental Health.
2. Report of Sub-Committee on Training in Mental Health in Teachers' Colleges.
3. Report of the Ad Hoc Committee on Research.
4. Interim Report on Mental Health Services.
5. Dinner address by Dr. Warren T. Vaughan, Director of Community Services, Massachusetts State Department of Mental Health and Associate Director, Task Force on Pattern of Patient care of the Joint Commission on Mental Illness and Health. His subject, "Patterns of Community Psychiatry".
6. Appointment of Chairman.

The reports presented by each committee chairman were discussed at great length and vigorous enthusiasm. Of particular interest and importance at this time is the report submitted by the Ad Hoc Committee on Research. C.M.H.A. will be doing an outstanding job in this field when their proposed plan gets underway.

Considerable time was spent on the very lengthy and important Interim Report of the Committee on Mental Health Services.

Dr. Vaughan gave a detailed and interesting insight into his work in assessing the various Community Psychiatric Services. He stressed chiefly the need for more and better undergraduate and postgraduate training for psychiatrists for leadership in Public Health Psychiatry.

Dr. R. O. Jones was appointed chairman for the next three years of the National Scientific Planning Council of C.M.H.A. replacing Dr. B. H. McNeel who has served so well.

E. S. GODDARD, M.D.

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## Report of Ad Hoc Committee on Standards and Accreditation of Mental Hospitals

I have the honour to present the following report of your Ad Hoc Committee on Standards and Accreditation of Mental Hospitals.

At the Annual Meeting in Edmonton in June 1957, the Committee, as constituted in 1956, was directed to continue to explore all possible means of developing a satisfactory relationship with the Canadian Commission on Accreditation of Hospitals and ways and means of financing the inspection of mental hospitals.

In December 1957 the chairman was invited to attend a meeting of the Canadian Commission and met with a friendly reception. The members of the Commission indicated that they themselves were concerned with proper mental hospital standards; that they were in favour of the idea of a special audit of mental hospitals; that they did not feel the general hospital audit was adequate, and that they would welcome collaboration with the C.P.A. on some basis to be negotiated. They indicated willingness to give serious consideration to including the C.P.A. as a member of the Canadian Commission, but indicated also that a seat on the Commission would cost $2,500.00 a year. Since it was apparent that even if the C.P.A. could subscribe this amount, it would hardly be sufficient to cover the inspection of the mental hospitals in Canada on a scale that would be satisfactory, the suggestion was made that the funding of inspections might be more realistic if mental hospitals became members of their provincial hospital associations. (Only provincial hospital associations receive fees. The Canadian Hospital Association as such does not receive fees.)

The question was raised whether the inspection of mental hospitals could be carried out satisfactorily by the regular inspectors appointed by the Commission, provided that these inspectors were given a brief orientation on the functions and expectations of mental hospitals and the standards required. I expressed the opinion that the few days orientation would scarcely be sufficient to equip even an experienced inspector of general hospitals to inspect mental hospitals but that it would be preferable for the Commission to appoint inspectors nominated by C.P.A. from the ranks of psychiatrists with experience in mental hospital administration. This opinion was supported by a number of the members of the Commission.

As an evidence of their unwillingness to proceed with a unilateral arrangement to inspect mental hospitals a motion was made and passed that the Canadian Commission would inform the Joint Commission that it would not proceed to inspect nineteen Canadian hospitals which had been referred to it by the Joint Commission until the Canadian Commission had established satisfactory standards. The members of the Commission then indicated their wish that the Canadian Psychiatric Association should be involved in the establishment of such standards.

The results of this meeting were reported to the meeting of the Board of Directors of the C.P.A. on January 23, 1958, and the Board of Directors indicated their wish that our Committee should continue to explore means of financing an inspection service, and associating the C.P.A. with the Canadian Commission.

In April of this year, the chairman of the Committee had further discussions with Dr. Taylor of the Canadian Commission. As a result of these discussions the suggestion was made to the Committee that the inspection of mental hospitals by the regular inspectors of the Commission might be feasible provided that:

(a) the criteria for inspection can be clearly defined so that the report is made factual and not subject too much to personal opinion.

(b) the Inspectors have a period of orientation under the direction of one or more competent Mental Hospital Administrators.

(c) the Inspectors' reports are subject to the scrutiny of a Mental Hospital Committee drawn from the ranks of members of the C.P.A. who are familiar with mental hospital administration.

Since the Canadian Commission has not yet completed its forms and instructions for the inspection of hospitals, the survey report forms used by the Joint Commission on Accreditation of Hospitals were forwarded to the Committee for Study, to determine whether it might be possible to devise a form that when completed, would provide sufficient factual data to give an adequate picture of psychiatric treatment facilities and program. It was felt that the greater our success in establishing clear-cut criteria for the assessment of mental hospitals, the greater would be the likelihood of establishing an inspection procedure that would be both satisfactory and economical.

These matters are still under consideration as, unfortunately, the meeting of the Committee set for May 15th, had to be cancelled.

An approach has also been made to the Ontario Hospital Association to determine the views of the Association on establishing a special membership fee for mental hospitals to provide for the financing of an inspection service. Similar approaches will have to be made in each Province since the Canadian Hospital Association which is a member of the Canadian Commission receives fees from the Provincial Associations and not directly from the hospitals. The fees charged to hospitals by the Provincial associations vary from Province to Province.

In Ontario the general membership fee is $1.25 per bed per year up to 400 beds, plus 60 cents per bed for additional beds over 400, up to a maximum fee of $900.00 per year.

It has been suggested to the Executive Director of the O.H.A. that the principal benefit to be derived by mental hospitals from membership in the Association is eligibility for inspection by the Canadian Commission and that if a special membership can be considered, the cost of membership should be closely related to the cost of providing inspection services. This matter is yet to be taken up with the Board of Directors of the O.H.A. and a full discussion is still in the future.

Respectfully submitted.

BURDETT H. MCNEEL, M.D.
Chairman

This report was presented by Dr. McNeel who moved its adoption. Seconded by Dr. Lawson.

During discussion, it was made clear that this Committee was at this time concerned with mental hospitals although it would at a later date consider mental deficiency hospitals and psychiatric units in general hospitals. Accreditation was described as a primary and valuable way of raising standards of service with secondary value in the field of undergraduate and postgraduate education. Motion carried.

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## Report of the Committee on Psychiatric Education

I have the honour to present the following report of the work of your Committee on Psychiatric Education to this present meeting. Following the meeting in Edmonton in June of 1957, the Committee which reported at that meeting was reappointed and asked to examine further into the questions that they had been discussing during the previous year. The same Nucleus Committee was set up, composed of Dr. F. A. Dunsworth, Dr. Myer Mendelson, and Dr. R. O. Jones, Chairman — all of Halifax. The corresponding members of the Committee were as follows: Dr. J. Fraizer Walsh, Dr. W. W. Black, Dr. M. N. Beck, Dr. C. A. Martin, Dr. Taylor Statten, Dr. A. M. Doyle, Dr. F. R. Chalke, Dr. G. C. Sisler, Dr. F. E. Coburn, Dr. R. R. MacLean, and Dr. G. A. Davidson.

At a special meeting of the Nucleus Committee held on September 27, 1957 it was decided to ask Dr. Burdett McNeel, Chief of the Mental Health Division of the Province of Ontario to become a Committee member since we felt that a very large mass of opinion in the provincial services of Ontario was not adequately represented on the Committee. Dr. McNeel kindly agreed to act with us and has been a tower of strength to the Committee. At this initial meeting the Committee went on to discuss two matters — one of which had been left over from last year and the other a new problem which had come to us from Dr. John Dewan, the Chairman of the Committee on Psychiatry of the Royal College of Physicians and Surgeons of Canada. Following a lengthy discussion by the Nucleus Committee, minutes were circulated to all the corresponding members of the Committee; and they were asked to not only give their own opinions on the questions raised but also to try to canvass opinion in their province and to give us as broad a picture as possible of this opinion. The Nucleus Committee is very grateful for the response that the corresponding members have given to this request and would wish to express their thanks for the large amount of work that so many of these people have put into the preparing of this report. Briefly the replies received from provincial representatives represent the following pooling of opinions.

*Newfoundland* — Dr. Walsh has given us a very full statement of his feelings in the matter and in addition has attached letters from four other psychiatrists certainly representing the bulk of Canadian Psychiatric Association membership in that province.

*Nova Scotia* — The report of the Nucleus Committee was presented at a meeting of the Nova Scotia Division of the Canadian Psychiatric Association and fully discussed.

*New Brunswick* — The report was submitted at the meeting of the recently organized New Brunswick Division of the Canadian Psychiatric Association.

*Prince Edward Island* — The report was presented at a meeting attended by all the psychiatrists in Prince Edward Island. The whole evening was devoted to its discussion.

*Quebec* — A reply has only been received from the member representing English-speaking psychiatry in Quebec; but in addition to his own report, he appends letters from four other psychiatrists in that province.

*Ontario* — Reports have been received from two of the three corresponding members in that province.

*Manitoba* — A report has been received from the Committee representative from this province without mention of how widely it has been discussed.

*Saskatchewan* — The situation is as stated in Manitoba.

*Alberta* — A report has been received from the Committee representative in Alberta who states that he has discussed the report with his confreres in that province.

*British Columbia* — The Committee representative from British Columbia presented the report before the Neuropsychiatric Section of the Vancouver Medical Society where it was fully discussed.

It is then the opinion of the Nucleus Committee that every effort has been made to get a representative opinion from across Canada and that if there are positive indications of Canadian opinion in the material that we have collected we cannot do less than present it to the Board of Directors as our recommendation for the planning of psychiatric education in Canada and ask that they take appropriate action. From a careful survey of the material collected in this way, your Committee would make the following recommendations.

1. *Reciprocity of Training Institutions with the American Board of Psychiatry and Neurology.*

There is some feeling in Canada that there should be reciprocity between the diploma of the American Board and the Certification Examination of the Royal College of Physicians and Surgeons of Canada. Others are of the opinion that the reciprocity should extend to training institutions; that is, that one examining body would accept training in institutions approved by the other examining body but that the diploma and Certification should not be

looked on as being necessarily the same. The Royal College should keep control of the actual requirements for sitting the Certification examination having to do with the time spent in various training facilities and so on. The Committee on Psychiatric Education favours this second viewpoint and would suggest that the Board of Directors enter into communication with the American Board of Psychiatry and Neurology to determine the feasibility of an institution approved for training by one of these bodies being automatically accepted by the other. The latest statement of the Royal College in this matter seems to indicate that they have already adopted this position in their "list of Canadian hospitals approved for advanced graduate training by the Royal College of Physicians and Surgeons" as of February 28, 1957 they make the following statement.

"*Residency Training in the United States of America*

Residency training in hospitals in the United States will be accepted when taken in hospitals approved for resident training in medicine and the medical specialties, or pathology by the Council on Medical Education and Hospitals of the American Medical Association. A directory of approved hospitals may be obtained from:

The Council on Medical Education and Hospitals,
535 North Dearborn Street,
Chicago 10, Illinois, U.S.A."

A reciprocal statement by the American Board of Psychiatry and Neurology that they would accept training centers in Canada which were listed as approved by the Royal College of Physicians and Surgeons of Canada would seem to meet the situation adequately.

2. *Requirements for Certification Examination by the Royal College of Physicians of Canada.*

Last year the Committee attempted to examine the present requirements for Certification examination, and to bring them closer in line with training schemes as presently operating in Canada and at the same time to have them achieve the aims in psychiatric education which were originally formulated at the time of setting up the Certification exam. As everyone knows, their efforts last year stirred up a considerable furor. It was very obvious that there were strong bodies of opinion in Canada on what the requirements should be to sit the Certification examination. The Nucleus Committee examined the situation very carefully and felt that the principles of psychiatric education which were laid down in the original report of June 21, 1957 were valid and they saw no reason for change. On the contrary, they felt these were very strong reasons for adhering to the policies which the Committee had recommended at that report. (These reasons are set out in the attached memorandum.) They determined then to make this recommendation to the corresponding members; and as I have mentioned above ask that these members attempt to get as wide an expression of opinion across Canada on this matter as they could possibly obtain. This, we believe, has been moderately well carried out, and the summary of the results of this country-wide survey are as follows:

Replies have now been received from Committee members in each province of Canada and as I have noted above they very frequently expressed not only their own opinions but that of the opinion of most psychiatrists in the province in which they reside. The summary of the results of this survey is as follows:

1. *Against the Training Regulations Proposed in the Original Committee Report of June 21, 1957 — One.* This representative who is clearly against this proposal enclosed letters from four other psychiatrists in his province — one of which is against the Committee's formulation — and the other three of which are not clearly for or against. However, the provincial opinion as expressed by their representative is against making any changes in the present regulations.

2. *Doubtful — Where no Positive Reports have been arrived at* — Two. One of the provinces classified in this group submitted the question to a meeting of their Division of the Canadian Psychiatric Association and discussion apparently waged hot and heavy. No final decision was arrived at. In the other province the Committee representative says that he feels that the opinions expressed in the report of June 21, 1957 were valid; but he does not feel that it would be politic to present them at this moment.

3. *For the Regulations as Recommended in the Original Report of June 21, 1957* — Seven. Among these seven provinces who I have recorded as in favour of the regulations in the Committee's June report, three submitted the report of the Nucleus Committee to general meetings of their psychiatric associations. In one province where every psychiatrist in the province was present, the vote was unanimously in support of the Committee's recommendations. In the second province there was a well-attended meeting with no dissenting vote, but one member who was not present would like to have his vote recorded as being against the Committee's conclusions. In the third province, there were apparently no dissenting votes. In

the province where the material was not presented to a general meeting, the opinion from the representative from one province is supported by four letters from prominent psychiatrists in the province — one of them the Assistant Superintendent of a large mental hospital and the other the Clinical Director of a large mental hospital. From a second province, two reports have been received — one from the Director of Mental Health Division of the Department of Health in the province and the other a Professor of Psychiatry in the province—both in favour of the Committee's conclusions. In the third province, the report has come apparently only from the Committee member who is a Professor of Psychiatry in the University of that province. In the fourth province, the report comes over the name of the Committee member who is the Director of Mental Health Services in the province but he states that he has discussed the matter with his confreres in the province and all are in agreement with the Committee report.

Considering these figures, it would seem that there can be no doubt that the majority of Canadian psychiatric opinion supports the principles enunciated in the original report of the Committee on Psychiatric Education and presented to the Board of Directors in Edmonton on June 21, 1957.

The Committee regards this survey of Canadian Psychiatric opinion as a very strong positive directive to recommend to the Board of Directors that the principles as enunciated in the original report of June 21, 1957 be accepted and acted on by the Board of Directors. The general principle involved is that psychiatric education in Canada leading to the sitting of the Certification Examination of the Royal College of Physicians and Surgeons should involve four years of training after an approved general interneship. Two of these years of training should be considered as years in which the resident is involved in an intensive teaching experience in an organized training program of a University Department of Psychiatry. The other two years involve more emphasis on learning through training and supervised clinical experience but are no less important in the total overall program. They must include a minimum of six months and preferably a year in a setting allowing experience of long term care of psychotic patients with all the opportunities for teaching which this involves. The final year may be selected from a variety of different clinical experiences. The order of training may vary from student to student depending on individual circumstances; but all four years should be conducted under university supervision. Specifically the statement in the Royal College regulations would read as follows:

1. *Certification Examination in Psychiatry*
    1. An approved general interneship of at least one year.
    2. Four years of graduate training in addition to the general interneship. This period must include:
        (a) Two years approved resident training in psychiatry with the resident participating in the organized training program of a University Department of Psychiatry. During this period there would be:
            1. Experience on the psychiatric services of a general hospital.
            2. Experience on an Outpatient Clinic dealing with community problems.
            3. Experience in child guidance, in psychosomatic medicine, and on a Neurological Service.
            4. Other settings approved by the university to meet special needs and which permit participation in the university teaching program.

During this intensive training period there should be contact with other medical disciplines and with the basic specialities in psychiatry, neurophysiology, psychology, social work, sociology, etc. Individual supervision of psychotherapy should make up a very considerable part of this teaching experience. Training should be so arranged that resident-teacher contact and resident patient contact goes on over a prolonged period and should not be repeatedly broken. These years should be considered primarily teaching years and service considerations should be secondary during this time. Definite teaching hours should be set aside, and the resident's case load must be small enough to allow him to participate in teaching sessions, to read, and to integrate his experiences.

(b) Two years of training which must include at least a six-month period and preferably one year, in a hospital providing an opportunity for the study of the comprehensive care of psychotic patients for a sufficiently long period to permit the resident to observe the natural course of the illness and its treatment. During such time the resident will be trained in the technique, understanding, and proper utilization of special methods of therapy, for example, coma insulin, drug therapy, occupational therapy, milieu therapy, group dynamics, activity therapy, and the rehabilitation process. In addition an opportunity should be given for training in medical-legal problems peculiar to this type of institution.

(c) One year of this time may be selected from the following:

1. A further period of approved resident training as under (a)
2. A further period in the setting already described under (b)
3. A year in the full time study of a related basic science; such as Neuroanatomy, Neurophysiology, Psychology or Sociology in a Department approved by the University concerned.
4. Six months of approved full time study of a basic science and six months of approved resident training in Internal Medicine, Pediatrics, or other branches of medical practice related to Psychiatry.
5. One year in an approved course of study and training at a hospital or university center in Canada or abroad approved by the University concerned.
6. A period in a psychiatric specialty; for example, Child Psychiatry, Mental Deficiency, Research, Community Psychiatry, etc.

During all four years the candidate should be registered in a training course of the university of his choice — such university assuming responsibility for the standards of training in the area concerned.

Following the initial report of the Nucleus Committee, other matters have come to the attention of the Committee on Psychiatric Education; and they would make the following recommendations to the Board of Directors.

1. *The inclusion of a psychiatric examination in the examinations of the Medical Council of Canada.*

It is the feeling of the Committee that it will be very difficult to have the Medical Council of Canada accept such a proposition; but that an attempt should be made both by a direct approach to the Medical Council and by individual contact of psychiatrists with Medical Council members in their area. It is the feeling of the Committee that exclusion of Psychiatry from these examinations is not in accord with the importance of psychiatric problems in general medical practice and tends to lower the medical student's estimation of the value of psychiatry. We would, therefore, recommend to the Board of Directors that steps be taken to urge the inclusion of a psychiatric examination in the examinations of the Medical Council of Canada.

2. *The Fellowship of the Royal College of Physicians and Surgeons of Canada*

There has been a very lengthy discussion of this, and there is unanimity of opinion that the present Fellowship in Medicine as modified for Psychiatry is completely unsatisfactory as a method of assessing excellence in the specialty of Psychiatry. It is our feeling that this qualification should either be dropped or that there should be a Fellowship in Psychiatry set up. This Fellowship in Psychiatry would require the same standards of training as the Certification in Psychiatry but the examination should be at a different level. As a suggestion the instruction given to examiners at the moment are that the Certification in a specialty indicates competency for good practice in that specialty whereas the Fellowship indicates the sort of competency one would expect in the teacher of the specialty; that is, an ability to discuss theoretical considerations, historical developments, etc. which are desirable but not necessarily present. It is recommended that negotiations be entered into with the Royal College to try to change the present situation with regard to the Fellowship and that approaches be made to other specialty bodies to see if a united attempt could not be made to make this examination more acceptable to Canadian specialists. (Your Committee has already initiated this communication.)

3. *Consideration of Training in Child Psychiatry*

The Committee was presented with a questionnaire from Dr. Aldwyn Stokes outlining various possibilities regarding training in Child Psychiatry. It is the feeling of the Committee that there is no examination in Canada at the moment which certifies to special ability in Child Psychiatry and that no special recognition should be given while examinations are organized under the present system. It is the Committee's feeling that the person who wishes to specialize in Child Psychiatry should have a basic two years of training in Adult Psychiatry and then might spend his second two years in Child Psychiatry. If he wishes to qualify for a Fellowship in Child Psychiatry we would recommend that a year in the Pediatrics be added to the above requirements if the Fellowship Examination remains as presently set up. However, since we do not approve of the present Fellowship Examination, we would suggest that nothing be done in this area until we see if some change cannot be made in this.

4. *Approval of Hospitals by the Royal College for Psychiatric Training*

In the Committee's report of June 21, 1957, the present chaotic state of hospital approval in Psychiatry was pointed out. Nothing has been done as yet to make this situation any better and it appears to the Committee that it grows more confused all the time. The Committee would make the same recommendations to the Board of Directors that they made in the June report

of 1957. It is suggested that it be formally laid down that institutions seeking approval for training of candidates for Certification in Psychiatry be informed that an approach should be made by the institution concerned to the approving university in any particular area rather than directly to the College.

If the University feels that the institution making such an application can be incorporated into the university training scheme, such judgment being based solely on the merits of the hospital concerned, then the institution's application accompanied by a supporting note from the university should be forwarded for action to the Royal College Committee. In the event of disagreement by either the applying hospital or the supervising university, either party has the right to appeal to the appropriate body of the Royal College of Physicians and Surgeons in which is vested final authority. It is suggested that a statement of this kind appear in the Royal College regulations stating that the approval for all institutions will be automatically revoked on July 1, 1959. Institutions desiring to train residents in psychiatry would thus have an opportunity to submit their scheme to the university department concerned and gain approval. Thus, finally there would be some order in the Canadian training scheme.

Respectfully submitted,
ROBERT O. JONES, M.D.,
Chairman.

Dr. Jones moved, seconded by Dr. McNeel, that the sections dealing with the R.C.P. and S. be approved. This motion led to heated discussion with many arguments being presented pro and con. The cons stressed the need for further study, cautions regarding interpretation and felt that it was too rigid and might stifle future developments. The pros felt that it was very flexible, that it was, in fact, the policy presently being followed by the College and could only lead to improved training of residents with resultant benefits to all clinical services, including mental hospitals. After about thirty minutes discussion, Dr. Cameron moved, seconded by Dr. Hirsch, that the question be put. Motion carried. The President then requested a secret ballot on Dr. Jones' motion. The result of the ballot was that the motion was carried 36 to 17.

Dr. Jones then moved, seconded by Dr. Stokes, that the section of the report dealing with reciprocity of R.C.P.S. and American Boards be followed up by the Committee next year. Carried with Dr. Lawson opposed.

Dr. Jones moved, seconded by Dr. Sisler, that further efforts be made to have psychiatry included in the L.M.C.C. examinations. Carried.

Dr. Jones moved, seconded by Dr. Chalke, that further efforts be made to develop a more acceptable situation regarding the Fellowship in Psychiatry by the R.C.P. and S. Carried.

Dr. Jones moved, seconded by Dr. Stokes, that the Committee give further study to Child Psychiatry but no action to be taken until the Fellowship situation has been clarified. Carried.

Dr. Jones then moved acceptance of his report as presented. Seconded by Dr. Sisler. Carried with Dr. Lawson opposing.

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## Committee on Constitution

(Notice of motion of proposed changes in by-laws were mailed to each member in March, 1958, and are not repeated here).

Dr. Lawson reviewed the activities of his Committee. Notice of motion has been properly given he now moved, seconded by Dr. Stokes, that sections 3, 5, 6, 7, 20, 24, 25, 33, 34, 35, 38, 39, 49 (3) (i) (II), 50, 51 and 52 be amended as recommended in his report. Carried.

Dr. W. C. M. Scott then discussed his proposed amendment (the setting up of a Section in Child Psychiatry). In view of the Board of Directors recommendations he did not present his motion to the Annual Meeting.

Dr. Chalke moved, seconded by Dr. Stokes, that the Board of Directors for 1958-59 appoint a committee on Child Psychiatry to consider all matters related to that field of psychiatry. Carried.

* * * *

## Committee on Psychiatric Coverage in Hospital and Medical Insurance Plan

Once again your committee has attempted to keep itself informed on current developments within the medical and hospital insurance field.

The most important development in the past year is the announcement of the immediate implementation of the National Hospital Insurance Plan (Bill 320). This plan will be activated by provinces beginning as early as July 1st next in Manitoba.

The concern of the C.P.A. (and indeed of other bodies as well, most particularly the C.M.H.A.) has been with reference to the policy in connection with the hospital care of psychiatric patients. When the plan was first announced it was stated by the government that under no circumstances would the hospital insurance benefits be extended to the mentally ill

and in particular to the mental hospitals. Representations were made to the government by both the C.P.A. and C.M.H.A. but the only change in policy conceded was to include under the plan those psychiatric patients who are treated in psychiatric units of general hospitals. Representations have been made again by the C.P.A. but at present the policy has remained unchanged. The committee has noted with satisfaction, however, that in spite of this policy, certain provinces (Ontario for example) propose to include mental patients receiving treatment in mental hospitals under the Hospital Insurance scheme.

Apart from this, your committee has attempted to keep abreast of developments in the field of prepaid professionally approved medical care plans with respect to psychiatric treatment. In this connection, I would like to acknowledge gratefully the help furnished to us by Mr. C. Howard Shillington, Executive Director of the TransCanada Medical Plans.

During 1957, the T.C.M.P. made an informal survey of the number of qualified psychiatrists who are in present practice either full time or part time and who would be eligible to receive payments under a comprehensive prepaid medical care plan. The following breakdown is the result:

TABLE 1

| Province | Number of Psychiatrists eligible to receive payment for services (1957) |
|---|---|
| Prince Edward Island | 1 |
| New Brunswick | 3 |
| Newfoundland | no report |
| Nova Scotia | |
| Halifax | 11 * |
| Other parts | 4 * |
| Ontario | |
| Windsor | 5 * |
| P.S.I. | 75 * |
| Quebec | 99 |
| Manitoba | no report |
| Saskatchewan | |
| Regina | 2 ** |
| Saskatoon | 3 ** |
| Alberta | 7 * |
| British Columbia | 17 * |
| Total | 227 |

* Prepaid medical plan provides for payment for psychiatric treatment services now.
** Payment for initial consultation only.

The analysis of data supplied by those plans which are making some attempt to provide coverage for at least some psychiatric treatment for their subscribers is indicated in Table 2.

TABLE 2

Prepaid Medical Care Plans Reporting—1957

| | B.C. | Alta. | Ontario P.S.I. | Ontario Windsor | Maritime Medical Care |
|---|---|---|---|---|---|
| Total No. of Services per year | 10,830 | 5,270 | 13,561 | 2,528 | 2,140 |
| Total Cost | $48,803 | $34,114 | $67,512 | $8,158 | $5,106 |
| Average Cost per treatment | $4.51 | $6.47 | $4.98 | $3.23 | $2.38 |
| No. of services per 1000 member months | 2.47 | 1.97 | 1.77 | 1.06 | 1.99 |
| Electro Convulsive Therapy | | | | | |
| Total No. of Services per year | 710 | 2,082 | 2,808 | 232 | 495 |
| Total Cost | $ 3,196 | $16,524 | $13,892 | $696 | $8,260 |
| Average Cost per treatment | $4.50 | $7.93 | $4.95 | $3.00 | $14.58 |
| No. of services per 1000 member months | .16 | .78 | .37 | .10 | .46 |

It is obvious that the discrepancies (between payments provided by the Windsor plan for instance and payments made by the Alberta or the Maritimes program) require interpretation. This is not possible from the present data. It would appear, however, that the psychiatrists in private practice would be well advised to agree on some sort of standard for costing their services so that the insuring body can more easily arrive at a reliable actuarial forecast.

Generally speaking it can be said that the prepaid professionally approved medical care plans are interested now in gaining experience in paying for psychiatric services. The trend reported in previous years is continuing on a reasonably satisfactory basis.

Respectfully submitted,
J. D. GRIFFIN, M.D., Chairman.

This report was tabled by Dr. Griffin for information.

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## Committee on Relationships Between Psychologists and Psychiatrists

1. This Committee was asked by the Board of Directors of the Association to hold a "watching brief" on the relationships between Psychologists and Psychiatrists in our country. As far as can be determined these relationships at the present time are healthy.

2. In the Province of Quebec the new organization of Psychologists (The Corporation of Psychologists of Quebec) is awaiting final ratification of its by-laws by the Provincial Secretary. As soon as this has been done the corporation will be in business and will make possible through its membership the establishment of standards for the qualification of psychologists in that province.

3. Last year a new Provincial Association of Psychologists was organized in Manitoba and two years ago a similar organization was formed in Saskatchewan. In Saskatchewan the association is presently drafting a Bill dealing with the certification of Psychologists which in due course will be presented to the Provincial Legislature.

4. In Ontario a similar special Bill dealing with the certification of Psychologists is being drafted for presentation to the Ontario Legislature. In Ontario Dr. Kenneth Gray has been acting as consultant for the Ontario Psychological Association and the project was discussed with the College of Physicians and Surgeons. Several drafts of this Bill have been prepared but as far as can be determined no agreement on a final draft has yet been reached.

5. It is felt that an effort should be made to keep the Provincial Colleges of Physicians and Surgeons informed of Bills of this kind and that, further to this, a letter be sent from the Canadian Psychiatric Association to all Provincial Colleges of Physicians and Surgeons, informing them of the policy adopted by the Association three years ago in connection with the relationship between Clinical Psychologists and Psychiatrists. This policy stated among other things that where the Psychologist was dealing therapeutically with the mentally or emotionally ill person he should have close and continuous contact with a medically qualified psychotherapist.

6. The Committee on Mental Health Services of the National Scientific Planning Council (CMHA) chaired by Dr. James S. Tyhurst is presently studying the role of various professional personnel in the mental health field, including that of the Clinical Psychologist. An excellent and definitive working paper on this was prepared for the committee by Dr. Herbert Dorken in consultation with Professors Roger Myers and William Line. This statement forms part of a larger report on Personnel which it is hoped will be given limited circulation among professional people later this year and will form part of the final report of the committee to be published in 1960.

7. It is anticipated that this document will be helpful in clarifying the various roles of different professional people involved in mental health services in Canada.

Respectfully submitted,
J. D. GRIFFIN, M.D.

This report was tabled by Dr. Griffin for information.

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## Rehabilitation Committee

This committee was established in December 1957. A preliminary report was made on January 20, 1958, which outlined a plan of operation.

The present report outlines:

1. The progress of the committee's activities.
2. A preliminary statement by the nucleus committee.

1. *Progress of the Committee's Activities:*

In the light of the knowledge and experience of its members, the nucleus committee in Manitoba has discussed the relationship of psychiatry to the field of rehabilitation.

In an attempt to learn of the practices, plans and opinions across the country, a questionnaire was sent to the C.P.A. directors in each province, to the "coordinators of rehabilitation" in the nine provinces in which there are such offices, to the Deptuy Minister of Health in Quebec and to the Commissioner of the Yukon Territory.

To date, information has been received from three provincial coordinators of rehabilitation (one other indicated that the desired information could be obtained from a national

source). The Research and Statistics Division of the Department of National Health and Welfare plan to publish a comprehensive report in the fall of 1958 entitled "Rehabilitation Services in Canada". This may contain information of value to the committee. The National Coordinator of the Civilian Rehabilitation Branch of the Department of Labour has indicated that he will provide information regarding national practices and plans.

Replies to the questionnaire have been received from three provincial C.P.A. directors. (Two others have referred the request to a local physician specializing in rehabilitation).

Though it is not known what further response there will be to the questionnaire, and despite the current lack of information regarding the opinions of psychiatrists across the country, it appears worthwhile for the nucleus committee to attempt a preliminary statement. It is planned to circulate to the various provincial C.P.A. directors the following section of this report to stimulate local discussion and criticism.

2. *Preliminary Statement by the Nucleus Committee*:

Rehabilitation to optimal occupational and social functioning is the goal of good medical treatment. In addition to treatment by the physician, some patients with continuing disabilities require the assistance of members of social, educational, psychological and other disciplines in order that this goal may be reached. In these cases it is of the greatest importance that the members of the medical and other disciplines assisting each patient, are in close communication and understand each other's roles.

2. (a) *The Role of Psychiatry in Rehabilitation Programs for the Physically Handicapped.*

Either the present practice or the goal of most of these programs is to establish a central provincial agency to coordinate assessment, treatment, retraining and job placement. There is wide variation in the administrative organizations in the various provinces. In some, the central agency is a branch of a government department; in others it is a separate organization. The size of the agency varies from a few persons to dozens. The agency in some provinces deals with individual cases itself; in others, part or all of such functions are delegated to other organizations, many of which are concerned with specific diseases – e.g. blindness, tuberculosis, or with groups designated in other ways – e.g. by race (Indians).

Thus, in one geographical area there may be one or several agencies whose function is "rehabilitation". Most of the professional personnel of these agencies have social work or psychology training. Medical assessment and treatment is carried out in public clinics or by private physicians.

Psychiatric assessment is arranged in a number of ways:

1. By obtaining reports of previous assessments from a psychiatric resource (by "psychiatric resource" is meant a psychiatric clinic or hospital or a psychiatrist in private practice.)
2. By referring the patient to a psychiatric resource.
3. By having a consultant psychiatrist discuss with agency personnel the results of social, personality and physical assessment done by others. This assists in rehabilitation planning which may include referral to a psychiatric resource.

Psychiatric treatment is carried out by private psychiatrists or psychiatric clinics and hospitals. Some of the problems in this area are:

1. In general there are very insufficient numbers of psychiatric consultation and treatment facilities and personnel. This is due to a deficiency in numbers of available psychiatrists and psychiatric clinics in the local area and/or unawareness on the part of the agencies of the need for and value of psychiatric assistance.
2. The personnel of the agencies may have unrealistic expectations of the patients' potentiality for improvement with psychiatric treatment. The factor of deficient motivation, often a reflection of a neurosis or character disorder, accounts for many rehabilitation failures. A period of working together with the psychiatrist is often necessary before the agency personnel are able to appreciate the value and limitations of psychiatric treatment. In addition, this working together helps alert the psychiatrist to the overall rehabilitation problem.
3. Deficient communication between the psychiatric resource, the agency, and other medical personnel often causes delays in assessment and treatment. This deficiency may be in terms of time or understanding or both. It is decreased if agency and psychiatric resource are close geographically, have satisfactory communication between their respective social workers, and if a psychiatrist from the phychiatric resource is available at frequent intervals to discuss problem cases with agency personnel.

2. (b) *Rehabilitation Programs for the Mentally Ill*:

There appears to be no need for an agency apart from the psychiatric treatment team to take responsibility for the rehabilitation of the mentally ill. Though it is, of course, not possible or wise to separate absolutely the mentally from the physically ill, and there are "borderline" cases, the central problem here is concerned with the return to effective social function of those patients who have been or are being treated in a "psychiatric resource". Some are entirely well and not "disabled", and some have residual or recurrent symptoms. Many require continuing or periodic outpatient treatment and periodic inpatient treatment over a long period of time.

Though the shortage of trained personnel in these resources is a great problem, the rehabilitation of the patient is most satisfactorily planned and supervised by the psychiatrist, social worker, psychologist and other persons that participated (and often continue to participate) in his treatment.

Good mental hospitals, psychiatric wards in general hospitals and psychiatric clinics have always carried out this function and maintained liaison with job placement and social agencies. Psychiatrists in private practice are increasingly collaborating with psychologists and social workers, either in private practice or in clinics to improve the overall treatment of their patients.

The provincial coordinator of rehabilitation can be of assistance in coordinating planning between these workers and on the psychiatric team and other agencies. Local voluntary mental health organizations may also assist and cooperate with the psychiatric team in arranging for living accommodation, group recreational activities, etc., for patients who are in the process of social readjustment. The main problem is the deficiency in numbers of trained personnel for the psychiatric team.

The geographic blocks to effective follow-up after mental hospital discharge will persist so long as many patients are hospitalized long distances from their homes. However, even in these cases, because of their training and experience, the personnel of the local psychiatric clinic on referral of the patient from the distant hospital can carry out rehabilitation plans better than another agency.

Respectfully submitted,
G. Sisler, M.D., Chairman.

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## First Canadian Mental Hospital Institute

This report was presented by Dr. Roberts on behalf of Dr. Jackson. It was also reported that the Directors have decided to go ahead with a Second Institute in 1960 and had authorized the payment of the deficit in the First Institute. Dr. Roberts, seconded by Dr. McNeel, moved acceptance of this report, including the action of the Directors, and included a vote of thanks to Dr. Jackson and her Committee. Carried unanimously.

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## Committee on Research

The present chairman was appointed in January 1958. No meetings of this Committee were possible, but a report was submitted to the Board of Directors of the Canadian Psychiatric Association at their meeting in Toronto, January 23, 1958. Since that time, the Federal Government has set up a national committee to study the financing of medical research in Canada. This committee, under the chairmanship of Dr. Ray Farquharson consists of Dr. Copp of British Columbia, Dr. Doupe of Manitoba, Dr. Ettinger of Ontario, Dr. Robillard, University of Montreal, Dr. Gingras, University of Laval, Dr. Chester Stewart, University of Dalhousie and Dr. Cameron of McGill University. This committee has been considering some of the wide problems already outlined to the Board of Directors in January, 1958. These matters are:

1. the amount of money available
2. the areas covered by funding bodies
3. the stability of the research worker's career.

The four major funding departments have cooperated with this committee in this study and it is anticipated that a report will be made to the Federal Government in October 1958.

Respectfully Submitted,
D. E. Cameron, Chairman.

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## The Joint CMA/CPA Committee

Your Committee begs to report that most of its work has of necessity been carried on by means of correspondence but an actual meeting was held in Halifax, on June 19, 1958 at which were present three representatives from each Organization.

Since the previous meeting, the Chairman, Dr. D. Ewen Cameron, has, in accordance with the request of the Committee, canvassed the opinion of all the professors of Psychiatry in Canada with respect to their opinion as to (1) the desirability of providing psychiatric instruction during the first year of internship and (2) whether, if one month of such instruction were decided upon, each center could undertake to provide training facilities for junior interns in that area. It was reported to the Committee that the consensus of opinion was to the effect that such facilities would be provided if the requirement was for a one-month psychiatric training period.

From the subsequent discussion, it developed that the Committee felt that, rather than recommend a specific length of time, it would be wiser in view of other developments that are going on in this area to recommend to the Canadian Psychiatric Association that it request the Canadian Medical Association to place before the teaching hospitals and other training centers the great desirability of improving the facilities for psychiatric training during the first year internship.

Your Committee also explored the feasibility of strengthening the relationship between the Canadian Medical Association and the Canadian Psychiatric Association at the provincial level and it was decided to ask the Canadian Psychiatric Association to recommend to the provincial psychiatric associations that they should attempt to develop working relationships with the provincial branches of the Canadian Medical Association. During the course of this discussion, it was brought out that – at least in some areas – the provision exists whereby if 60% of the membership in a specialty organization located within a given province belongs to the Canadian Medical Association, then such a body can seek affiliation with the respective provincial branch of the Canadian Medical Association, and that, if affiliation is granted, seat will be accorded to the provincial specialist body on the Executive Committee of the respective provincial branch of the Canadian Medical Association.

There was a brief discussion on our relationship with the College of General Practice of Canada and it was learned that that body expects to hear further from us concerning joint activities and we wish to recommend to the incoming committee that this matter should be further pursued.

Finally it was decided that the possibility may exist for the setting up of another Joint Committee at the proposed meetings of the Advisory Committee on Mental Health to the Minister of Health in Ottawa.

D. E. Cameron, M.D., Chairman

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**Nominating Committee**

The Nominating Committee Report was presented by the Secretary who moved its adoption. Seconded by Dr. Lawson. The Chairman called for nominations from the floor—there were none. The report was approved unanimously.

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There being no further business the meeting adjourned at 5.45 p.m.

# Book Reviews

"Autonomic Imbalance and the Hypothalamus: Implications for Physiology, Medicine, Psychology and Neuropsychiatry", by Ernst Gellhorn. University of Minnesota Press, Minneapolis, 1957.

The distinguished author of "The Physiological Foundations of Neurology and Psychiatry", published in 1953, which provided a valuable storehouse of information concerning up-to-date data on the physiology of the central nervous system, has applied himself to the writing of a shorter and what will in all probability be a very popular monograph, as it deals with concepts which lend themselves to use by the clinician in his attempt to set up theoretical constructs which help explain a variety of functional disturbances. If the reader pays attention to the detail of this book he will have difficulty in fashioning facile constructs but the danger lies in the probability that the evidence offered will not be weighed and that the new terms and concepts introduced may be bandied about by less serious students in a facile fashion in an endeavour to derive from this work ostensible support for ill based theorizing.

In his introduction, Gellhorn points out that autonomically innervated organs give diametrically opposed effects to stimuli, depending on their physiological state. A more important site of action which regulates different responses of autonomically innervated structures is the central representation of this system, and on this the author proposes to report in this book. The procedure was to alter the reactivity of the autonomic system by virtue of a stimulus which led to a "tuning", so that the system acquired a different "set" and would respond subsequently in a different fashion to a stimulus previously given. The autonomic centers were "tuned" reflexly towards greater sympathetic or parasympathetic responsiveness, or, directly at the hypothalamic level. States of autonomic imbalance were produced by physiological or pharmacological means, altering the excitability of either the anterior (parasympathetic) or posterior (sympathetic) division of this tissue. Gellhorn is quite aware of the important discoveries of Magoun and others whose work has recently shifted interest from the hypothalamus to the reticular formation but he avoids unsolved complexities by pointing out that it is very probable that the reticular formation and posterior hypothalamus change similarly in a variety of circumstances.

He emphasizes that, in contrast to the somatic nervous system, the autonomic behaves rather irregularly. For example, vagal stimulation can lead to an increase in tone and contraction of the stomach if the activity of the organ is low, but to an opposite effect if the spontaneous activity is high. Likewise, the uterine reaction and blood vessel reactivity is dependent upon the chemical environment which exists. As a demonstration of what the author calls "sympathetic tuning", one may see that, following the injection of a hypotensive drug, reflex excitation of the sympathetic through the afferent stimulation of the sciatic nerve or directly by stimulation of the posterior hypothalamus, results in a much greater effect in terms of cardiac acceleration and other indicators of sympathetic nerve activity, than when such stimuli were given without the prior excitation of the sino-aortic receptors through the induction of the hypotension by the previously injected drug. In other words, one may have the following sequence: hypotensive drug – stimulation of sino-aortic receptors – stimulation of sympathetic centres in the hypothalamus and possibly elsewhere – activity in sympathetic effectors, giving greater results than otherwise would have been expected from the stimulus alone. The tuning effect could be demonstrated even when the hypotensive drug was applied in a dose too small to evoke a sympathetic reaction by itself. Proof that these drugs were not acting directly on the hypothalamus is shown by the fact that sino-aortic denervation eliminated the "tuning" effect of the hypotensive drugs or, in other words, the sympathetic tuning was the result of an alteration in central sympathetic reactivity through sino-aortic baroreceptor reflexes.

Conversely, parasympathetic "tuning" could be obtained by raising the blood pressure, inducing an increased responsiveness to parasympathetic stimuli. The mechanism involved in the state of "tuning" is based on the summation process, but is in fact a potentiation because it does not correspond to the algebraic summation of the two stimuli. It is apparent also that a parasympathetic stimulus is lessened in a state of sympathetic tuning, and vice versa. The author refers to the investigations of Losse, Kretschmer, Kubin, Bottger, whose studies indicate that a small proportion of people react to vasometer tests with a preponderant sympathetic response, and the majority in an autonomically mixed way. These authors indicated that the different responses were related to body structure and were dependent on genetic factors. Gellhorn goes on to say that the differences in autonomic reactivity occurring during emotion find their expression in different autonomic patterns, for as is well known some people blanch and others redden

with anger. And, as has been shown by Harold Wolff, the performance of standard exercise during emotional tension causes a greater and more persistent sympathetic response than when relaxed. Gellhorn's studies indicated that the effect of "tuning" was more marked on one organ than on another, a finding which concurs with the observations of Wolff.

The author argues that, since intrahypothalamic injection of pentotothal or procaine decreased the responsiveness to direct stimulation or the sympathetic effects produced by a hypotensive drug, the action of hypotensive drugs may be taken as a measure of sympathetic hypothalamic excitability. Under these circumstances histamine and mecholyl hypotension is prolonged. Metrazol and strychnine injected in the hypothalamus had the opposite effect. He argues that normal alterations in the state of arousal apparently alter the response to a drug. For example, a hypotensive drug given during sleep was followed by a slower return of blood pressure than when given during a period of arousal. Inhalation of 5 to 8% carbon dioxide increased the excitability of the hypothalamus and return of blood pressure. Conversely, diminution of the excitability of the anterior hypothalamus by injection of barbiturates or by appropriately placed bilateral lesions reduced the pulse slowing effect of the pressor effect of noradrenaline.

Studying the hypertensive and hypotensive response of a large group of normal human beings to 10 mg. mecholyl injected intramuscularly, it was found that the young showed a much higher incidence of sympathetic response – that is, a hypertensive response, whereas in the aged this incidence was greatly decreased, indicating that sympathetic central reactivity decreases with increasing age. The same was found in a large group of over 200 psychotics. This finding may reconcile some of the conflicting findings reported for the Funkenstein test.

Gellhorn goes on to point out that the last 10 years' work have indicated that the hypothalamus exerts an influence on the cerebral cortex. For example, if the posterior hypothalamus is stimulated electrically, one sees a rage reaction, as well as autonomic developments. It is further indicated that the cortex is not only subjected to hypothalamic impulses, but gives rise to impulses important for the excitability of the hypothalamus. There is, therefore, an upward and downward hypothalamic feedback between it and the cerebral cortex, and in this complicated mechanism it has been shown that the diffuse multisynaptic system of Magoun sends impulses from the reticular formation of the brain stem to the posterior hypothalamus, and from both structures to the cortex via the diffuse projection system of the thalamus. Further understanding of these mechanisms should throw light on the action of psychopharmacological agents and the influence of psychotherapy.

A good deal of attention is paid to Funkenstein's work, which has been described recently in his book, "Mastery of Stress". Briefly, it may be pointed out that the mecholyl test performed on students showing anxiety or anger at themselves (depression) were hyporeactors, while those angry at others reacted with a considerable increase in blood pressure. Responses showed less difference when both groups were relaxed. This data is related to the possible secretion of adrenaline in the former and noradrenaline in the latter, and certain physiological work by von Euler. Gellhorn details the physiological reasons why, in anger, the concentration of noradrenaline should be high in the blood and urine, while in fear or anxiety, the adrenaline content should be increased.

Reference is made to Bernard's ideas about the constancy of the internal environment and Cannon's elaboration of it, in terms of the concept homeostasis. The modifications which are required by the data recorded in this book considerably alter Cannon's original views. The chapter in which these matters are

discussed, viz. 13, is not simple reading and requires the most meticulous attention and familiarity with the literature to extract the unquestionably valid portions.

The summary and conclusions given in 12 pages, are so condensed that, unless one is familiar with the author's work or has read a large part of the book, there is scant expectation that much can be derived. In an epilogue, Gellhorn makes some philosophical remarks and an apology for attempting possibly the impossible, but he feels that a greater knowledge of the hypothalamus and its relation to cortical function, and to the autonomic, is a means of approach for the further understanding of mental disease. He adds that it is not necessary for complete understanding to be achieved before progress can be made. While this is true it should be added that in this attempt, to find meaning in complexity he has perhaps oversimplified the picture so that the uninitiated may see certainty where it does not exist.

He concludes with the realistic and philosophical quotation "In Magnis Voluisse Sat" – "It is sufficient to have attempted great things".

R. A. CLEGHORN

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"The Alcohol Language": With a Selected Vocabulary. Brookside Monograph No. 2. Keller, Mark, and Seeley, John R. (Alcoholism Research Foundation). (University of Toronto Press, 1958, 32 pp., $1.50.

The substance of this small and rather costly text is contained in the article and dictionary (pages 7-23) written by Keller – the rest appears superfluous.

A considerable ambiguity exists in "the language of alcohol problems", to the point where it might seem that we have separate vocabularies for public, patients and professionals and even the latter are not in agreement among themselves. For example, temperance has two common definitions: moderation, abstinence; while six are given for alcoholism.

Mr. Keller points out that: "The method of most attempts . . . is to provide a new or substitute term for a described condition, or an improved or modified definition of an old term. Neither the authoritative position of a proponent nor the irrefragable logic of a proposal has usually succeeded in modifying established usage. "By recourse to a method based on the common practice in lexicography he argues: "that the solution of this problem can be advanced more effectively by giving due recognition to a basic fact in the situation: that the power of usage is as decisive in a special field as in language generally." The dictionary is based chiefly on North American usage.

HERBERT DÖRKEN, Ph.D.,

# Letter to the Editor

Aro Hospital,
Abeokuta, Nigeria.
August 3, 1958.

The Editor, C.P.A.J.:

I have been intending to write to you for some time but thought I might as well wait until I had a fairly clear picture of the psychiatric situation here in Nigeria.

I have been here almost 11 months now and the time has gone very quickly. The Nigerian government has treated me very well . . . I have a fine big house with a garden full of tropical shrubs and flowers and a car. Aro hospital is situated in the country about 4 miles from Abeokuta, a fairly large rather primitive village some 40 miles inland from the coast. We are on the top of a hill and the climate is cooler and drier than the steaming swamps and jungle along the coast. As a matter of fact the climate is very pleasant . . . the mornings particularly . . . it is cool and everything is cleanly etched in the hard tropical sun.

The hospital has been in the process of building for about ten years and is still not finished (things move slowly in Africa!). We just started to take in patients last week. However we have developed a very fine system of treating psychosis, etc. on an out patient basis. We have a couple of huts set up as consultation room and E.C.T. room and have made negotiations with the chiefs in several of the local villages to house our patients and their relatives during the treatment period.

I have treated everything in this way . . . even the most disturbed psychotics who are frequently brought to the clinic in chains or handcuffs (the local people are very much frightened of psychotics and epileptics and think they have the strength of ten and that if they are bitten by one of them that they will get the disease too). We give them 100 mgms of Largactil and an E.C.T. or two on the first day and then they are quiet enough to move into the village safely in the care of their relatives.

This system has proved very successful. Rehabilitation problems are greatly reduced since they have never really left the social web, the cost is small, the patient is in familiar surroundings yet away from home on a kind of holiday. I have had no trouble thus far with suicide or injury to others. Suicide seems to be quite a bit less common than at home . . . perhaps due to lack of individuation and the feeling of individual responsibility or some other more obscure social or psychological element. Real self-castigating depression is also very rare except in the odd highly Europeanized patient. I have been wondering whether something like this village-out-patient system might not be applicable in Ontario. I suppose the average Ontario householder would not be as hospitable to the psychotic and his relative as the traditionally very hospitable Yoruba is . . . also I have the impression that psychotics are a bit wilder and the depressions a little more prone to self damage among Canadians than among these people. Still it might be worth a try some time.

The patterns of illness here are similar to Canadian ones but seem to be more amorphous especially in the un-detribalized group. There are however certain patterns missing . . . as I have said, real profound depressions as we see in involutional melancholia, etc. I have seen no alcoholic psychoses, either D.T.'s or the chronic delapitated states we see in Canada. It is difficult to say whether

alcoholism is very widespread–some certainly drink a lot of palm wine; G.P.I. and Tabes I have not seen; there is a striking lack of Obsessive compulsive illness and of obsessive compulsive elements in other types of illness (Schizophrenia, neuroses, etc.). This is perhaps due to the much less rigorous toilet training in these parts (if we are to accept the Freudian hypotheses). Similarly the character traits . . . meticulousness, rigidity, parsimoniousness, etc. are seldom met with in the average Yoruba . . . he is optimistic, pleasure loving, sloppy, irresponsible, and never on time for an appointment.

There does seem to be Schizophrenia. In the primitive group especially visual hallucinations are almost the rule in schizophrenia perhaps also with auditory hallucinations. At home I think visual hallucinations would immediately suggest an organic psychosis and I think this is a genuine difference between schizophrenia here and at home. I have seen two catatonic stupors with cerea flexibilitas, many excitements, some with a manic flavour but mostly of catatonic type. Especially in the detribalized group, there is often a considerable grandiosity (more common than at home I believe) . . . he has many university degrees, has been conferred many high honours, he is Aristotle or the Lord Mayor, director of a firm, etc. The theme of having done some great and unpardonable wrong seems to be absent in the schizophrenias as well as the depressions. Hallucinations are regarded as the voices of spirits or dead people or as their images (in the case of visual hallucinations) without the medium of "radio" or "television". Young children (and animals) are thought to have the ability to see spirits up until the age of speech; people regain this power when they become psychotic.

There seems to be very numerous groups of patients that fit into the "pseudo-neurotic Schizophrenic" group (or as I believe in the continuum theory of mental illness, into the transitional group) these present with numerous somatic complaints often of bizarre nature and are very difficult to treat and chronic. The head seems to be the chief focus of complaints . . . pain, burning crawling sensation, etc. Incidentally the pattern of somatic complaint seems to be different than at home. "Internal heat" is an almost universal complaint; burning of the skin as though pepper had been rubbed on it or the feeling that worms are crawling around the body are all extremely common and as I remember rather rare at home. These patients seem to have a lot flattening and are usually too preoccupied with their bodies to work.

In the neurotic group, simple anxiety states are common particularly in the detribalized group. Hysteria is much more common than at home I think. I have seen aphonias, breathing disorders, tics, astasis-abasia, paralyses, anaesthesias and one group of girls (two school teachers and several young students) who all developed hiccoughs and trance states . . . a kind of mass hysteria in a school.

The theory of causation of psychiatric (and physical) disturbance is almost universally along magical lines . . . witchcraft, evil spell "medicine", etc. About 75 to 80% of the patients that come to our clinic have first been to one or more native doctors (there are two types–"Babalawo's" who use predominantly magical modes of treatment, and "onishegun's" who use predominantly herbs). I have made the acquaintance of many of these native doctors and visited their treatment centres. Some of them seem to do a very good job in the treatment of psychiatric illness. They also seem to have some form of effective sleeping potions, the nature of which they keep very much secret. Much of their magical treatment is based upon "divination" of the person who caused the illness (they divine by a complex system of throwing beads on a special tray and observing the configuration, etc.). When the cause has been divined the patient must sacrifice to a certain god and the native doctor uses incantations to reverse the

malevolent psychic force back to its origin. Basically their theory of causation of psychiatric disturbance is not so different from our own . . . as due to interpersonal hostilities and guilts and "bad" desires, except that the location of these undesirable affects is projected upon witches and other evildoers instead of, as we seem to believe, in our own unconscious'. Sacrifice strengthens repression and the "bad force" is pushed back into the unconscious.

Apart from the psychiatric side, the social psychological side of the Yorubas is fascinating . . . their funeral ceremonies, ancestor worship, "spirit" dances, their complex traditional religion, the polygamous family structure, etc., etc. I am busy collecting material for a monograph on this subject, hoping to be able to bring in the detribalization effects to some extent, though this latter is very difficult to appraise and describe with any certainty.

The language problem is considerable. Yoruba is a tonal language with significance depending upon pitch of voice as well as form. The roots are completely different from Indo-european ones as is also the grammar. I have a tutor and am managing to make some headway . . . being now able to hold a simple conversation in the clinic and exchange pleasantries with the market women . . . however I'm sure it would be a matter of years before one could master the language to the depth required for accurate psychiatric work (at any rate for a very second rate linguist like myself!).

I have been trying to work out some sort of method of attack upon the difficult problem of the role of detribalization in the etiology of mental illness. I think most people feel that rapid social change is important and many people speak dogmatically about the "rapid increase in mental disturbance" in rapidly detribalizing areas. I do not know how they know this—there are certainly no statistics available! (here they do not even systematically record births or deaths, much less incidence of psychosis). Incidentally the native doctors I have spoken to do not think there has been any increase for what their opinion is worth.

I have worked out a research project that may be of some slight value along these lines. It is aimed at determining whether degree of detribalization has any closer relation to neurosis than to psychosis. One presumes that there is less organic or hereditary basis for neurosis than for psychosis and that detribilization would be more important in neurosis (???). At any rate I am collecting 100 cases each of neurosis and psychosis and 100 cases of epilepsy to act as a kind of control. On these 300 cases I am trying to assess their degree of detribalization through a questionnaire . . . with questions as to their marriage pattern, their religion, the religion of their parents, their education, if any, their occupation, whether they wear shoes, etc. . . . a kind of Index of Detribalization.

I must say that this country is a real paradise for research work . . . both social and psychiatric. I am sure that the sending of a proper research team here . . . psychiatrist, social worker (or sociologist), psychologist and secretary would be extremely profitable . . .

Yours sincerely,

Raymond Prince, M.D.*

*Dr. Prince, a graduate of the University of Western Ontario, who completed his post graduate training in psychiatry in London, Ont. wrote the above letter to Dr. G. E. Hobbs, an editor of this Journal and Professor of Psychiatry at the University of Western Ontario.

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